DOCUMENT RESUME

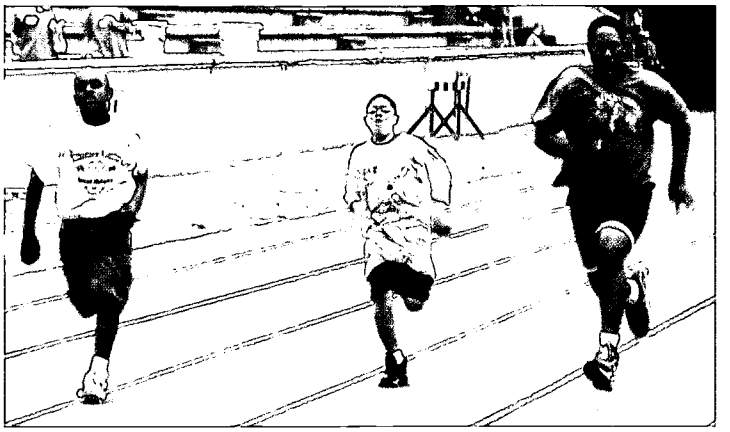
ED 451 889 PS 029 332

TITLE	KIDS COUNT in Virginia, 2001 [Data Book].
INSTITUTION	Action Alliance for Virginia's Children and Youth, Richmond.
SPONS AGENCY	Annie E. Casey Foundation, Baltimore, MD.
ISSN	ISSN-1532-9216
PUB DATE	2001-00-00
NOTE	65p.; Support also provided by the Children's Hospital of the King's Daughters, Inova Health System, and Carilion Medical Center for Children. Published bi-annually. For 1999 Data Book, see ED 427 856.
AVAILABLE FROM	Action Alliance for Virginia's Children and Youth, 701 East Franklin Street, Suite 807, Richmond, VA 23219. Tel: 804-649-0184; Fax: 804-649-0161; e-mail: actionalliance@vakids.org; Web site: http://www.vakids.org.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Academic Achievement; Accidents; Acquired Immune Deficiency Syndrome; Adolescents; Birth Weight; Births to Single Women; Child Abuse; Child Advocacy; Child Health; Child Neglect; *Child Welfare; *Children; Day Care; Delinquency; Demography; Dropout Rate; Early Parenthood; Economic Status; Elementary Secondary Education; Foster Care; Infants; Lunch Programs; Mental Health; Mortality Rate; Poverty; Preschool Education; Smoking; *Social Indicators; State Surveys; Statistical Surveys; Substance Abuse; *Trend Analysis; Violence; *Well Being; Youth Problems
IDENTIFIERS	Child Mortality; *Indicators; *Virginia

ABSTRACT

This Kids Count data book details statewide trends in the well-being of Virginia's children. The statistical portrait is based on the following four areas of children's well-being: health and safety; education; family; and economy. Key indicators examined are: (1) prenatal care; (2) low birth weight babies; (3) infant mortality; (4) child abuse or neglect; (5) child death; (6) teen violent death; (7) delinquency; (8) juvenile violent crime arrests; (9) high school dropouts; (10) special education eligibility; (11) student promotion in grades K-3; (12) child day care capacity; (13) births to teenage girls (14) births to single mothers; (15) children in foster care; (16) school lunch program participants; (17) children receiving TANF; (18) unemployment rate; and (19) average per capita income. Following a brief profile of each indicator on a statewide basis, special issues for Virginia's youth are addressed, including early care and education, children's mental health, prevention of violence, childhood injury, developmental disabilities, poverty, tobacco usage, nutrition and exercise, HIV/AIDS, dental health, substance abuse, insurance, homelessness, and family stress and turbulence. The report concludes with references, a description of the Action Alliance, the ten critical threats to America's children, and facts about Virginia. (Contains 62 references/endnotes.) (SD)

Action Alliance for Virginia's Children and Youth



KIDS COUNT in Virginia 2001

KIDS COUNT in Virginia is a program of the Action Alliance for Virginia's Children and Youth.

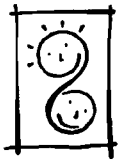
KIDS COUNT in Virginia is part of a national network of statewide organizations, coordinated by the Annie E. Casey Foundation, that focus on the well-being of young people and their families. This 2001 KIDS COUNT in Virginia data book—and its complement, the Internet database—are the Commonwealth's most comprehensive resource about the quality of life of young people, from newborns through adolescents.

Virginia-specific locality data (for each of the 95 counties and 40 independent cities in the Commonwealth) are available online. Accessing this data requires a one-time logon fee. For more information, visit the Action Alliance web site (www.vakids.org - & click on "KIDS COUNT") or telephone the Action Alliance at (804) 649-0184.

A generous supporter of KIDS COUNT in Virginia 2001 is:

INOVA® HEALTH SYSTEM

KIDS COUNT in Virginia 2001



Action Alliance
for Virginia's Children & Youth

701 East Franklin Street, Suite 807
Richmond, VA 23219
Tel.: (804) 649-0184 FAX: (804) 649-0161
e-mail: actionalliance@vakids.org
web site: www.vakids.org

ISSN: 1532-9216

Appreciation is extended to the following for assistance in the preparation of 2001 KIDS COUNT in Virginia data and text:

Chuck Baldwin - *Virginia Department of Social Services*
Janet Christopher - *Virginia Department of Education*
Terry Daugherty - *Virginia Department of Education*
Ronald Dill, Jr.
Susan Gholston
Nan McKenney - *Virginia Department of Social Services*
Petra Menzel - *Virginia Emergency Medical Services for Children*
Dawn Midgette - *Children's Hospital of The King's Daughters*
Mary C. Nienow
Fred Orelove - *Virginia Institute for Developmental Disabilities*
Marie Pees - *US Census Bureau*
Patricia Popp - *Project HOPE*
Steve Pullen - *Virginia Department of Juvenile Justice*
Paul Raskopf - *Virginia Department of Education*
Calvin Reynolds - *Virginia Department of Health*
Heather Shisler - *Special Olympics Virginia*
Tom Steinhouser - *Virginia Department of Social Services*
Margaret Vance - *Virginia Department of Social Services*
Mary Lynn White - *VCU Child Development Center*

PHOTO CREDITS:

Children's Hospital of The King's Daughters

Special Olympics Virginia

Virginia Commonwealth University Child Development Center

Virginia Emergency Medical Services for Children program

GENEROUS SUPPORT FOR 2001 KIDS COUNT IN VIRGINIA PROVIDED BY:

ANNIE E. CASEY FOUNDATION
CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS
INOVA HEALTH SYSTEM
CARILION MEDICAL CENTER FOR CHILDREN

The KIDS COUNT in Virginia 2001 data book and database represent more than just a collection of numbers and information. The data provided paint a picture of the health and well-being of Virginia's young people. While numbers rarely describe the entire story, they can be used to assess situations in a locality or region.

Data do not necessarily provide answers. Mostly, they are a powerful guide for asking the right questions. The indicators in this project were carefully chosen because, together, they reflect the well-being of Virginia children of diverse ages, health status, and socioeconomic situations. We have worked hard to present accurate, reliable, and objective information about young people in the Commonwealth.

As you examine this information (and that on the web site), be aware that there are limitations to data. Some indicators are composite measures of more than the obvious category. (For example, the standard infant mortality rate combines deaths from birth defects, illnesses, vehicular accidents, and severe abuse—all of which have different causes and policy implications and require diferent actions. While this indicator is factual in real numbers, it may not immediately tell the complete story.) Also, many localities in Virginia have small populations and relatively small numbers of events (raw numbers). Rates based on small numbers are often considered unreliable, unstable, and misleading. What may be a small change in the actual number (for example, from 3 to 5) may produce large changes in the calculated rate. It is difficult to identify real trends over time when rates show large, random fluctuations. And, for some areas of concern, collected data may not be available.

Data do not have personality or emotions, but the people they represent do. Remember that behind each of these numbers (and those on the web site) is a child's life. The effective use of these data becomes your responsibility.

Thank you for helping us show that kids count in Virginia!

WHAT'S NEW ABOUT 2001 KIDS COUNT IN VIRGINIA?

Along with our new look, we have implemented some requested changes in how KIDS COUNT in Virginia provides its data product. Over the years, users of our data book and database have suggested modifications in the ways we deliver information. We listened, and have implemented some new features that we hope will make 2001 KIDS COUNT in Virginia easier to use and a more informative tool. We are really pleased with the changes, and hope you will be, too!

The **data for each locality** (and for the Commonwealth as a whole) are on the Internet, rather than printed in a book. For those individuals who do not have access to the Internet, printed-out data pages (for two specified localities) are provided with the purchase of the data book.

Children's well-being in the Commonwealth is monitored through **19 indicators**—in the categories of Health & Safety, Education, Families, and Economy. Some indicators are no longer monitored by KIDS COUNT in Virginia—either because the data source agencies have ceased collecting the information, or because the information is readily available elsewhere.

For the data presented in this project, many localities in Virginia report small numbers of occurrences (or raw numbers). Calculating **rates** based on small numbers can be misleading. What may be a small change in a number of occurrences (for example, from 2 to 4) may produce large changes in the calculated rate (in this case, a 100% increase). It is difficult to identify real trends over time when rates show large, random fluctuations; circumstances may appear to have gotten suddenly much better or worse, when, in fact, they have not. For this reason, in the 2001 KIDS COUNT in Virginia database and the graphical representations in this data book, rates were not calculated when fewer than 10 events (or raw numbers) were reported.
However, in an effort to provide as much information as possible, data for each locality on the database include **both the raw numbers and rates** (when calculated) for each indicator.

On an average day in Virginia . . .

261 children are born:
- **40 did not receive prenatal care**
- **20 weigh less than 5.5 pounds**
- **9 are born to mothers younger than 18**
- **76 are born to single women**

2 children die before their first birthday

23 children are found to be abused/neglected

1 child (ages 12-14) dies

3 youths (to age 18) are arrested for a violent crime

175 young people are processed for a delinquent offense

CONTENTS

HEALTH AND SAFETY

Measures that reflect the health and safety of children are important in assessing overall well-being, and they are related to each other. In order for a child to grow and to thrive, he or she needs to feel safe and protected. Our society expects that most children will experience good health and encounter little—if any—harm.

Fortunately, most children in the Commonwealth are born healthy and do not face serious threats to their well-being. However, this is not true for all young people in the Commonwealth. The indicators included in this category—prenatal care beginning in the first trimester, low birth-weight babies, infant mortality, founded victims of child abuse or neglect, child death rate, teen violent death rate, intake cases involving delinquency, and juveniles arrested for violent crimes—present information about the health and safety of children in the Commonwealth.

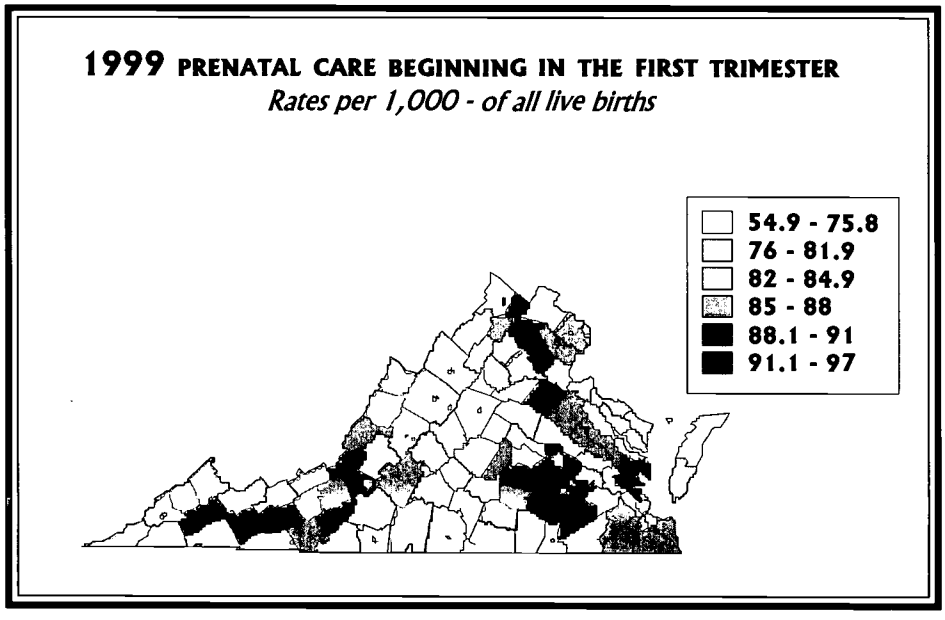
Virginia-specific locality data for each of these indicators is available online. Accessing this data requires a one-time logon fee. For more information, visit the Action Alliance web site (www.vakids.org - & click on "KIDS COUNT") or telephone the Action Alliance at (804) 649-0184.

NOTE: The *Special Topics* section in this book (p. 31) addresses additional issues related to children's health and safety.

PRENATAL CARE BEGINNING IN THE FIRST TRIMESTER

DEFINITION: Early prenatal care is defined as seeing a health care provider during the first three months of pregnancy.
Locality refers to the mother's reported residence.

Adequate prenatal care generally results in a pregnant woman's earlier education for proper nutrition, exercise, and avoidance of alcohol and drugs. The adequacy of care is determined by both the early receipt of prenatal care (within the first trimester) and an appropriate number of prenatal care visits for each stage of pregnancy.



Most of a baby's organ systems are formed by the time the fetus is 12 weeks old. The American College of Obstetrics and Gynecology recommends at least 13 prenatal visits in a normal nine-month pregnancy: one each month for the first 28 weeks of pregnancy, one every two weeks until 36 weeks, and then weekly until birth.

Receiving prenatal care late in a pregnancy, or receiving no prenatal care at all, can lead to negative health outcomes for mother and child. Women who receive care late in their pregnancy—or who receive no care at all—are at increased risk of bearing infants who are of low birth weight, who are stillborn, or who die within the first year of life, and they are more likely to experience pregnancy complications.

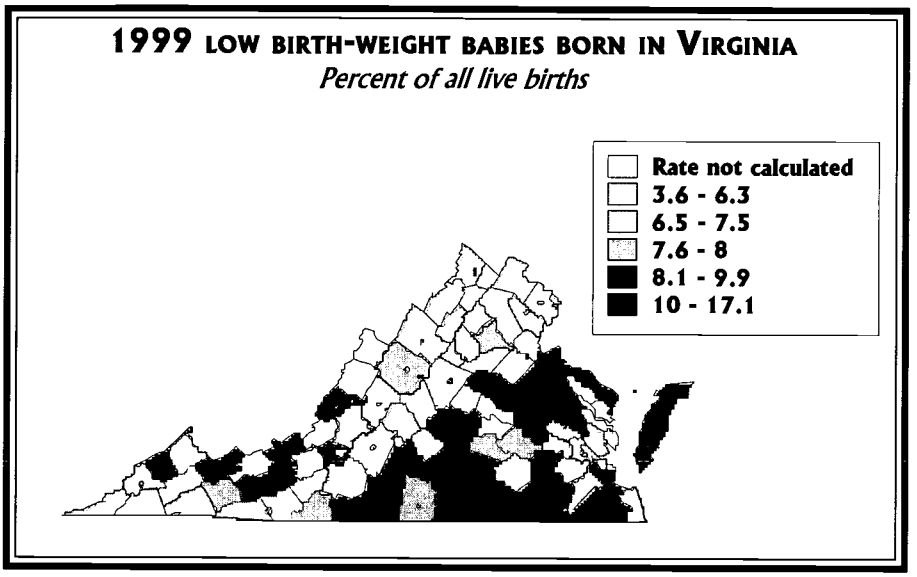
Not seeking or receiving adequate prenatal care is often an indicator of a child's future health care: *Pediatrics* magazine reports that women who do not seek adequate prenatal care during their pregnancy are less likely to obtain well-child care or complete immunizations for their children after they are born.

Research indicates that the pregnant women who are least likely to receive adequate prenatal care are adolescent, black, or of low income.

CALCULATION FOR RATES: (the number of pregnant females receiving care in the first trimester/ total number of live births) x 100

SOURCE OF RAW DATA: Virginia Department of Health

LOW BIRTH-WEIGHT BABIES



DEFINITION: A baby is classified as having a low birth weight if he or she is born weighing less than 2,500 grams (5 pounds, 8 ounces).
These data are based on the mother's reported locality of residence.

Babies born weighing less than five-and-one-half pounds face an increased risk of physical and developmental complications and death. The National Center for Health Statistics finds that these low birth-weight babies account for 4 of 5 of all deaths in the first month of life, and that they are 24 times more likely to die during the first year of life than are heavier infants.

Some documented risk factors that result in low birth weights are: mothers smoking during pregnancy, mothers who are at either end of the age spectrum (very young or more advanced in age), and multiple births.
Research has shown that low birth weight is associated with respiratory problems (including the onset of asthma and increased susceptibility to the air pollutant ozone), sensory impairment, developmental and learning disabilities, behavioral adjustment disorders, poor academic achievement, and infant death. Low birth-weight infants are at increased risk for cerebral palsy, deafness, blindness, epilepsy, chronic lung disease, and attention-deficit disorders. Babies with low birth weights who survive are about three times more likely than other babies to experience mental retardation, sight and hearing deficiencies, growth and developmental problems, chronic lung and respiratory problems, and learning difficulties.

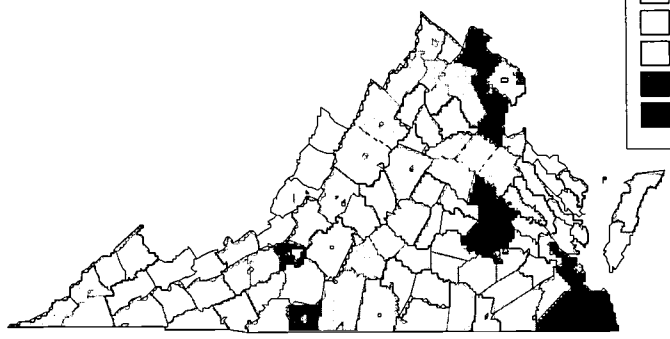
CALCULATION FOR RATES: (the number of babies born with low birth weights/ total number of live births) x 100

SOURCE OF RAW DATA: Virginia Department of Health

INFANT MORTALITY

DEFINITION: Infants who die during their first year of life are included in this measure.
Locality refers to the mother's reported place of residence, not the infant's place of death.

1998 INFANTS WHO DIED DURING THEIR FIRST YEAR OF LIFE
Actual events - raw numbers



This map represents actual death events; rates were not calculated for this chart because the occurrences-per-locality were mostly fewer than 10.

Infancy is defined as the first year of life, which can be a precarious and vulnerable time. This is especially true during the first month of life, when about 2 of 3 infants die.

The leading causes of infant mortality are: birth defects, disorders relating to premature births and low birth weight, and sudden infant death syndrome (SIDS).

Despite declines in the infant mortality rate in recent years, the US rate ranks among the highest of industrialized nations. The infant mortality rate reflects a community's overall well-being because it is associated with a variety of factors, such as maternal health, quality and access to medical care, nutrition, socio-economic conditions, and public health practices.

Typically, the infant mortality rate is twice as high for black babies, when compared to white babies.

The infant mortality rate is often regarded as an indicator of a community's overall well-being, as it reflects the health of pregnant women and infants, the conditions in which they live, and the parenting that infants receive.

SOURCE OF RAW DATA: Virginia Department of Health

1998 data are used here because 1999 data were not available from the Virginia Department of Health as of February 2001.

FOUNDED VICTIMS OF CHILD ABUSE OR NEGLECT

DEFINITION: This is the unduplicated number of children whose abuse or neglect has been founded (or substantiated) after an investigation by the local department of social services following the receipt of a report.

Abuse and/or neglect cause physical and emotional harm to children. Some short-term consequences are psychological and range from poor peer relations to violent behavior. There are many long-term effects of being abused or neglected—psychologically and economically—when children reach adulthood. Child maltreatment can result in serious injury or, in extreme cases, death.

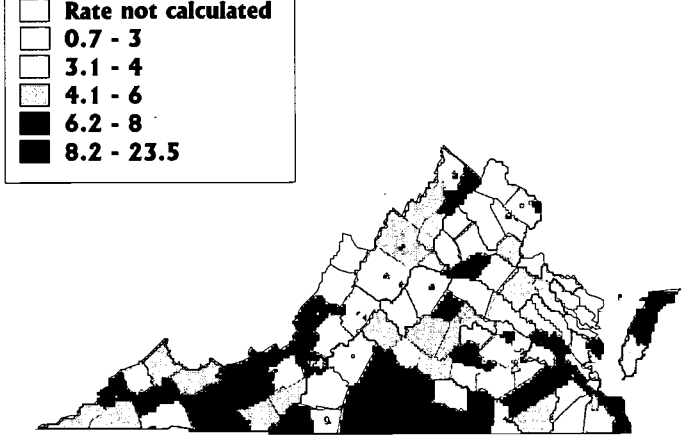
Adolescents with a history of abuse are at greater risk for becoming pregnant as a teenager than are females who are not abused, according to the Kaiser Family Foundation. A history of child maltreatment greatly increases the chances of juvenile arrest.[1]

Unfortunately, when families experience severe stress, children are often the victims; some of these stressors are increasing substance abuse by parents or caretakers, mounting poverty and economic responsibilities, a climate of violence within the home, and general family dysfunction. Severe violence has been found to occur more often in households with annual incomes below the poverty line.

The effects of child abuse reach far into adulthood. Recent research cited in the *Journal of the American Medical Association* found that abuse in early childhood dramatically changes the brain chemistry of women in later life, making them more vulnerable to anxiety disorders and more easily frustrated by stress as adults.

FY 98-99 FOUNDED VICTIMS OF CHILD ABUSE OR NEGLECT

Rates per 1,000 - ages 0-17

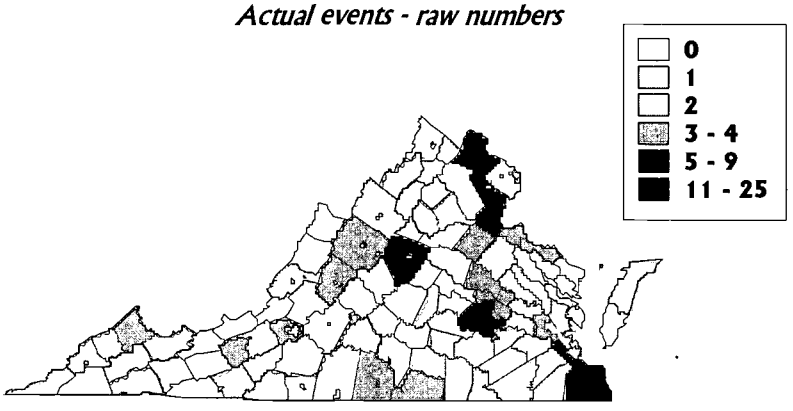


CALCULATION FOR RATES: (the number of affected children in founded cases/ population, ages 0-17) x 1,000

SOURCE OF RAW DATA: Virginia Department of Social Services

CHILD DEATH

1998 CHILDREN AGES 1-14 WHO DIED
Actual events - raw numbers



This map represents actual death events; rates were not calculated for this chart because the occurrences-per-locality were mostly fewer than 10.

DEFINITION: The deaths of children ages 1 to 14—regardless of cause—are included in this category.
The data are reported by the child's established locality of residence.

Due to medical advances during the past few decades, most deaths of young children are not related to illness; rather, they are due to "preventable events," such as injuries, accidents, and acts of violence. (*For a discussion of injuries—fatal and nonfatal—to children, see page 36.)* According to the US Department of Health and Human Services, the leading cause of death for children ages 1-4 is unintentional injuries; for children 5-14, all injuries—including the intentional ones such as homicide and suicide—are the leading causes of death.

The child death rate reflects the health of children, the level of adult supervision they receive, and the dangers to which children are exposed in their homes and communities.

SOURCE OF RAW DATA: Virginia Department of Health

1998 data are used here because 1999 data were not available from the Virginia Department of Health as of February 2001.

TEEN VIOLENT DEATH

DEFINITION: Violent deaths—homicide, suicide, accidents, motor vehicle crashes, and legal intervention—among 15-17 year-olds are reflected in this indicator.
The data are reported by the teen's place of residence.

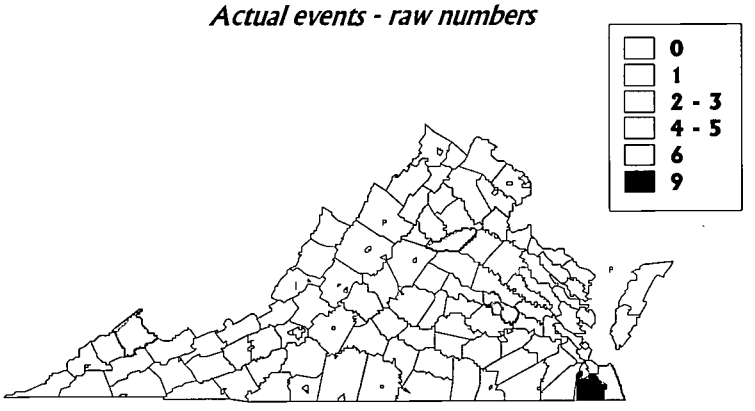
According to the Centers for Disease Control and Prevention, among adolescents 15-19 years old, one in every four deaths is caused by a firearm.

The leading cause of death for 15-17 year-olds is injuries, fueled by the recent "epidemic" of youth homicide and suicide. The increased usage and prevalence of firearms is often pointed to as a contributing factor to this surge of violence among teens. Because many juveniles have access to more sophisticated, more lethal weaponry, the "codes of conduct" that applied years ago—that told youth when to walk away, when to talk it out, and when to fight—no longer govern. In the past, conflicts were resolved in violent, but non-deadly ways; the accessibility to guns and the change in street rules often lead youth to resolve their disputes in more violent ways.

Factors that contribute to the occurrence of violent deaths among teenagers are: feelings of immortality, anger, desire to rebel, poor communication and nurturance in families, alcohol and substance abuse, access to handguns, poor education, and few educational opportunities.

High violent death rates among teens indicate the need for action and support from families and communities to minimize the associated risks.

1998 TEENAGERS AGES 15-17 WHO DIED VIOLENTLY
Actual events - raw numbers



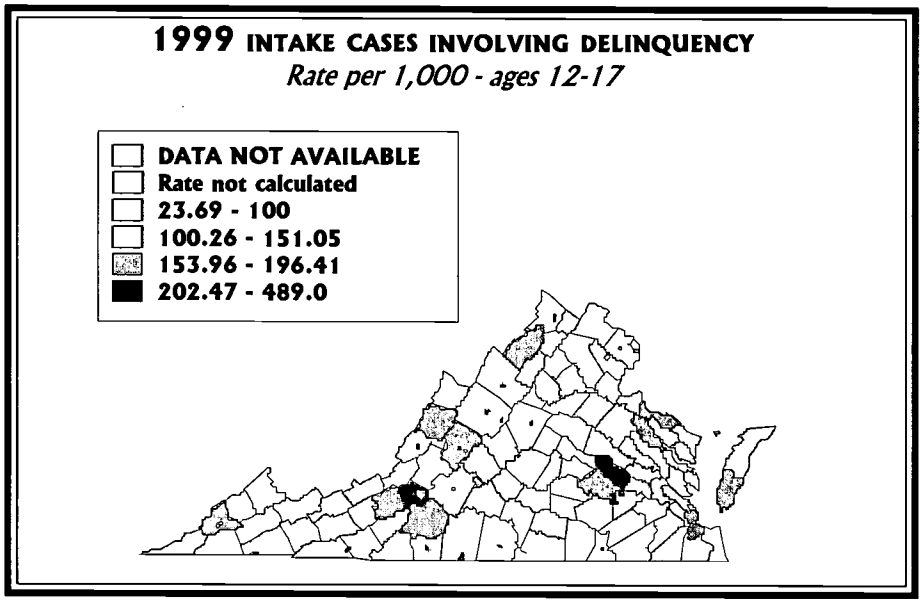
This map represents actual death events; rates were not calculated for this chart because the occurrences-per-locality were all fewer than 10.

SOURCE OF RAW DATA: Virginia Department of Health

1998 data are used here because 1999 data were not available from the Virginia Department of Health as of February 2001.

INTAKE CASES INVOLVING DELINQUENCY

DEFINITION: This category includes the total number of cases referred to intake (meant to divert youth from formal court actions) in a Court Service Unit for an alleged delinquency complaint. These cases may then be deemed unfounded, diverted, or petitioned to court by the Court Service Intake Staff.



Delinquency usually refers to behavior that would be criminal if the child were an adult. The legal system terms behavior that is illegal only if committed by a minor, such as running away, a status offense or unruly behavior.

Risk factors for juvenile crime and delinquency include a lack of education and job training opportunities, poverty, family violence, and inadequate supervision. Poor school performance, including falling behind one or more grade levels, increases the likelihood of involvement with the juvenile justice system. Other factors regularly associated with chronic delinquency include a history of antisocial behavior in childhood (such as frequent fighting, hitting, stealing, vandalism, or lying), perinatal difficulties, neurological and biological factors, low IQ, low verbal ability, parental criminality and substance abuse, and exposure to media violence.

CALCULATION FOR RATES: (number of intake cases for juveniles of all ages/population, ages 12-17) x 1,000

SOURCE OF RAW DATA: Virginia Department of Juvenile Justice

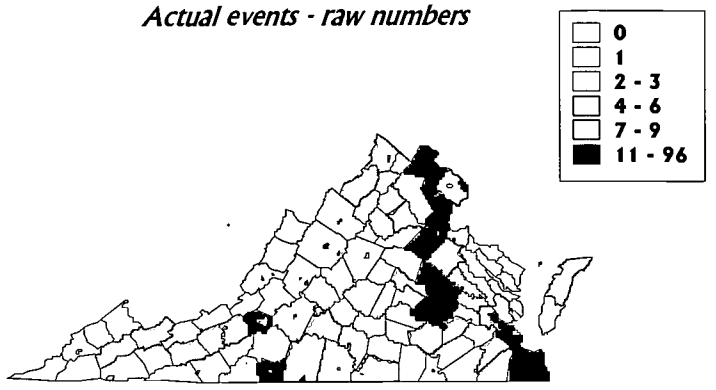
For calculations in this project, intake data include juveniles of all ages; population data are for juveniles 12-17. Therefore, the rates may be slightly over-estimated. It should be noted that the numbers of intake cases here are the best estimates, given the available data. Some localities do not provide a report for every month of the year—sometimes because there are no cases, sometimes for other reasons. The impact of this practice on the accuracy of these estimates cannot be determined.

JUVENILES ARRESTED FOR VIOLENT CRIMES

DEFINITION: This item includes the total number of arrests of juveniles (of all ages) for murder, forcible rape, robbery, and aggravated assault.

1999 JUVENILES ARRESTED FOR VIOLENT CRIMES

Actual events - raw numbers



This map represents actual arrest events; rates were not calculated for this chart because the occurrences-per-locallty were mostly fewer than 10.

This indicator is a good measure of juveniles at high risk for continued serious delinquency and criminal behavior. It reflects the preponderance of criminal activity in the community and different levels of community tolerance and police activity.

Nationally, the arrest rates for these violent crimes (as determined by the Federal Bureau of Investigation) are consistently much higher among males than among females over time and across all ages.

For this indicator, crime is reported in an incident-based format, which began in 1994. At that time, all contributing agencies were given five years to convert their summary system into an incident-based system. All agencies have not completed this process; therefore, for this year (1999) only, complete statewide totals for Virginia were not provided. Estimates, based on data from other sources, are supplied.

SOURCE OF RAW DATA: 1999 *Crime in Virginia*, compiled by the Uniform Crime Reporting Section, Virginia Department of State Police.

Arrests of juveniles on college or university campuses, federal property, or other locations not classified as a city or county are not included in this indicator. These data are for arrests; the number of actual convictions may be substantially lower. Arrest data include juveniles of all ages.

EDUCATION

One of the most fundamental indicators of a child's future well-being is education. A good education provides a path to personal growth, responsible citizenship, and economic welfare. Global competition and the growing demand of the workplace make the benefits of education a necessity for each child and the key to our future.

The inability to succeed academically negatively impacts children. The 2000 National Longitudinal Study of Adolescent Health found that teens who are failing school and spending a lot of unsupervised time with friends are at high risk for a number of dangerous behaviors, including drinking alcohol, carrying and using weapons, smoking cigarettes, and engaging in early sexual activities. And, studies have shown that educational attainment is negatively correlated with poverty, which means that the more education a person has, the less likely he or she is to be poor.

Included in this category are: 9th - 12th graders who dropped out of school, students eligible for special education services, students promoted in kindergarten - 3rd grade, and child day care capacity. Data for most of the indicators in this cluster are provided by the Virginia Department of Education and pertain to students in public schools in the Commonwealth. Although the majority of school-age children in Virginia are enrolled in public schools, there are other options, including home schooling and private schooling, which account for thousands of young people in Virginia.

Virginia-specific locality data for each of these indicators is available online. Accessing this data requires a one-time logon fee. For more information, visit the Action Alliance web site (www.vakids.org - & click on "KIDS COUNT") or telephone the Action Alliance at (804) 649-0184.

9TH - 12TH GRADERS WHO DROPPED OUT OF SCHOOL

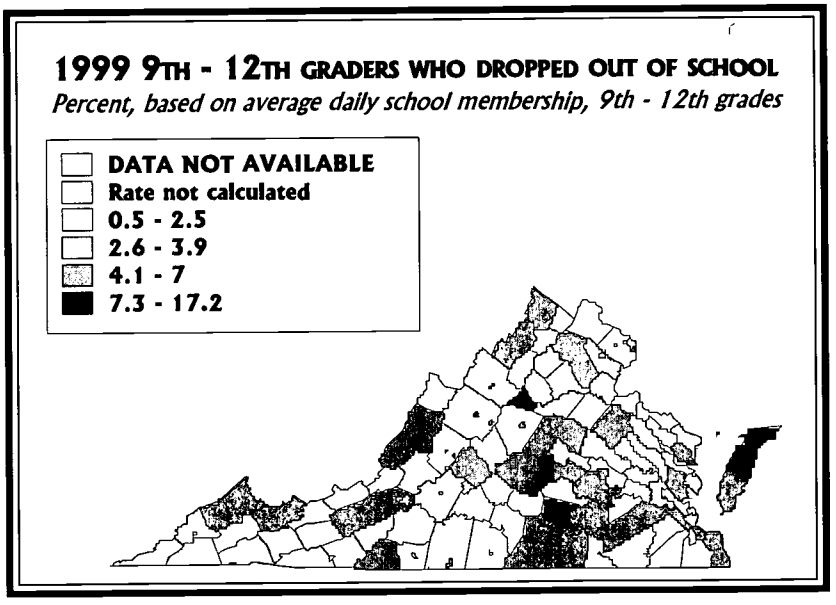
DEFINITION: These data indicate the number of students in grades 9-12 who leave school and do not graduate.

High school dropouts have lower earnings, experience more unemployment, and are more likely to end up on welfare than their peers who complete high school, according to the US Department of Education. Research has shown that female high school dropouts are more likely to become pregnant and give birth at a young age and are more likely to become single parents.

On average, young people who drop out of school will earn about one-third less income than high school graduates and less than one-half of what college graduates earn. Dropouts are nearly 4 times as likely as high school graduates to be arrested, and 6 times as likely to become unmarried parents.[2]

Research suggests that potential dropouts can be identified as early as third grade: predictors include the inability to read at grade level, poverty, and being retained a grade.[3]

High school graduation rates reflect a community's success in educating its children. They also can predict adult success: because many jobs require a high school diploma, employment opportunities are limited for those who do not graduate.



CALCULATION FOR RATES: (the number of students in grades 9 - 12 who leave school/average daily school membership for grades 9-12) x 100

SOURCE OF RAW DATA: Virginia Department of Education

STUDENTS ELIGIBLE FOR SPECIAL EDUCATION SERVICES

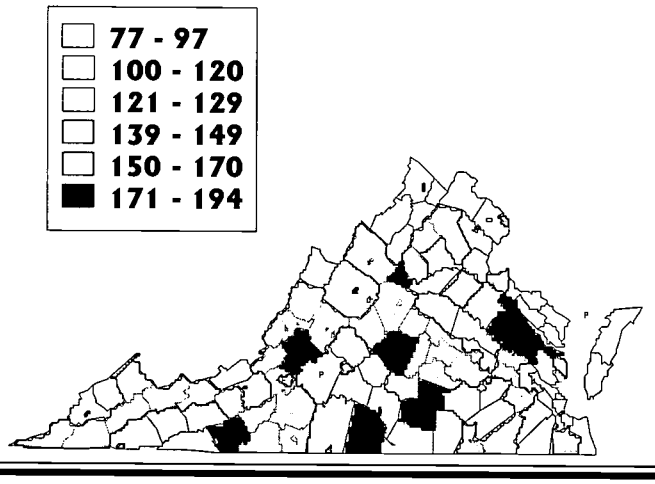
DEFINITION: This indicator reflects the number of Virginia public school students ages 6 to 18, who, because of a diagnosis of mental or physical conditions, are deemed eligible for special education.

Special education placements reflect both children with serious disabilities and those with mild learning and behavioral problems who have not been accommodated successfully by a non-specialized educational program.

The Center for the Future of Children estimates the cost of special education to be 2.3 times that of regular education, and the cost is borne primarily by local school districts.

1999 STUDENTS 6-18 ELIGIBLE FOR SPECIAL EDUCATION SERVICES

Rate per 1,000 - average daily school membership



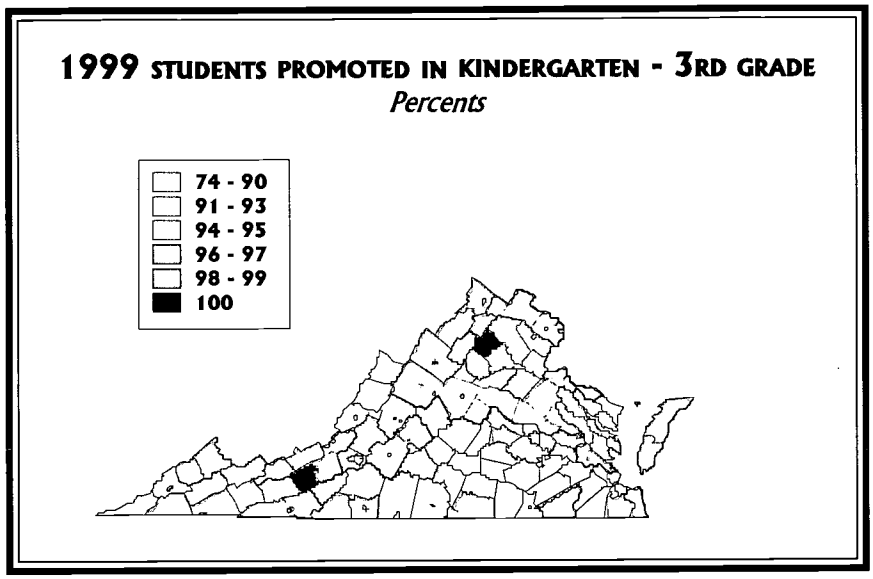
For more information on this topic, see the essay on developmental disabilities that begins on page 40.

CALCULATION FOR RATES: (the number of students ages 6-18 eligible for special education/average daily school membership) x 1,000

SOURCE OF RAW DATA: Virginia Department of Education

STUDENTS PROMOTED IN GRADES K-3

DEFINITION: This indicator reflects the number of Virginia public school students promoted (or passed to the next grade level) in kindergarten - 3rd grade.



Children's early primary school experiences are associated with their adjustment to school and to their later school success. Whether or not a child is prepared to start school is often demonstrated by his or her early academic successes. Not being promoted to the next grade (or repeating a grade) at a young age may suggest that a child has started school without sufficient preparation and may have school-related problems in later years.

In addition to reflecting how ready a child is to enter school, this indicator may also measure the degree to which schools are able to respond to children from a variety of backgrounds.

Boys tend to repeat kindergarten and/or 1st grade at a higher rate than girls.[4] Some factors have been shown to strongly affect whether or not a child repeats a grade in school, including family socioeconomic status and maternal education levels (children whose mothers did not complete high school are more likely to be retained in an early grade).[5]

Researchers have shown an association with grade retention and increased rates of behavior problems in children and adolescents.

CALCULATION FOR RATES: (the number of children promoted in kindergarten - 3rd grade/the sum of children promoted and retained in kindergarten - 3rd grade) x 100

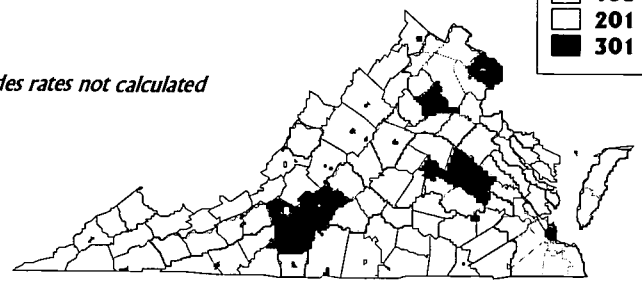
SOURCE OF RAW DATA: Virginia Department of Education

CHILD DAY CARE CAPACITY

DEFINITION: This item represents the total capacity in four categories of child care regulated by the Virginia Department of Social Services: licensed child day centers, licensed family day homes, church-exempt facilities (which are not licensed), and licensed short-term day care providers.

1999 CHILD DAY CARE CAPACITY

Rates per 1000, ages 0-11



Ages 0-11 were selected as the denominator for this rate because this age group most closely reflects the share of elementary school-age children who are likely to need child care.

As mothers have moved into the labor force, the child care needs of American families have grown substantially. Child care that is reliable and of high quality is especially important for infants and preschoolers because they are dependent on caregivers for their basic needs and safety.

These data are point-in-time data, as of April 1, 1999. It is important to note that all Virginia localities have child care available that is not licensed or regulated.

For more discussion of child care in the Commonwealth, and the Action Alliance's work in this area, see page 37.

CALCULATION FOR RATES: (total capacity of child day care facilities/total population, ages 0-11) x 1,000

SOURCE OF RAW DATA: Virginia Department of Social Services

FAMILY

Families have historically been the most important influence in a child's life. Children depend on their families for material needs, stimulation, and guidance. Research has shown that a family's well-being affects its children.

The indicators in this category—births to teenage girls, births to single mothers, and children in foster care—have all been shown to potentially adversely affect the lives of children involved.

Research has shown that children who live in fragile or "high-risk" families experience limited potential, an impaired sense of self, and a generally restricted chance for a successful life. The 1999 national *KIDS COUNT* data book (published by the Annie E. Casey Foundation) found that one of every 12 children in the Commonwealth lives in a "high-risk" family, where a number of these risk factors are present together.

Virginia-specific locality data for each of these indicators is available online. Accessing this data requires a one-time logon fee. For more information, visit the Action Alliance web site (www.vakids.org - & click on "KIDS COUNT") or telephone the Action Alliance at (804) 649-0184.

BIRTHS TO TEENAGE GIRLS

DEFINITION: This indicator represents the total number of live births to females, ages 15-17, in the Commonwealth.

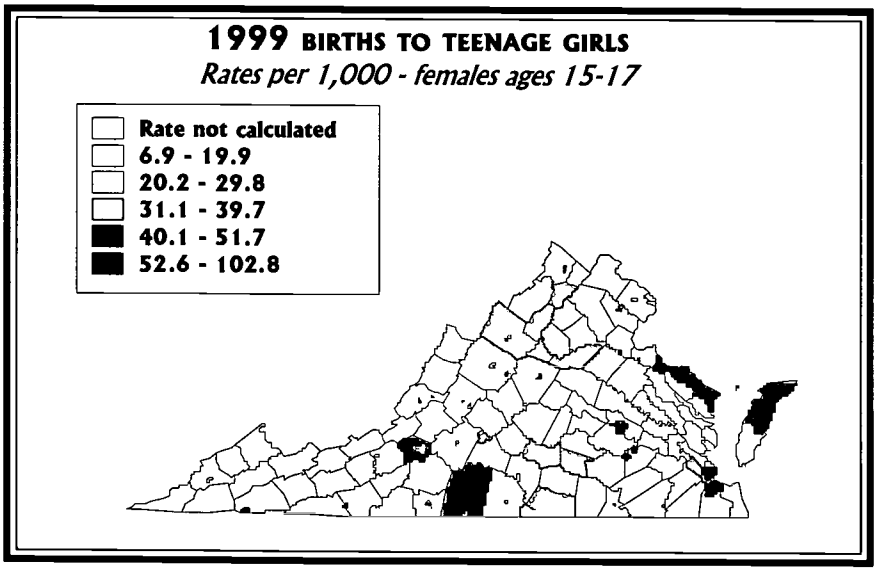
Locality refers to the mother's reported residence.

The US has the highest teen pregnancy, birth, and legal abortion rates among western nations.

The evidence is overwhelming that bearing a child during adolescence tends to limit the life options of both the parents and their children. A teenage mother may experience limitations in educational and employment opportunities; the likelihood that she will need public assistance is increased; and her children may experience negative developmental effects. Research indicates that children of teen mothers are twice as likely to be abused and neglected as children of older mothers;[6] that children of teen parents are more likely to be of low birth weight, to suffer from inadequate health care, to leave high school without graduating, and to be poor; that boys born to teen mothers are three times more likely to end up in jail; and that teen pregnancy costs taxpayers nearly $3,000 extra per teen mother.[7] The National Center for Chronic Disease Prevention and Health Promotion reports that public costs from teenage childbearing totaled $120 billion from 1985-1990; $48 billion could have been saved if these births had been postponed until the mother was at least 20 years old.

On average, adolescents do not receive prenatal care until the third trimester of pregnancy, according to the National Campaign to Prevent Teen Pregnancy. This increases the likelihood of health-related problems for the mother and child.

This is a relevant indicator, because about two of five American women become pregnant before the age of 20, and approximately half of those pregnancies result in live births.[8]



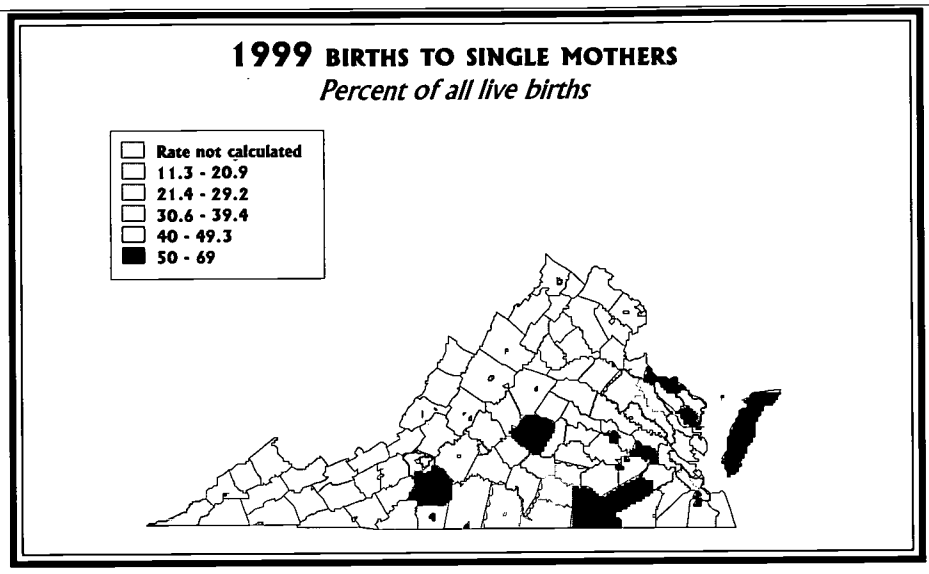
CALCULATION FOR RATES: (all live births to females, age 17 or younger/total population of females, ages 15-17) x 1,000

SOURCE OF RAW DATA: Virginia Department of Health

BIRTHS TO SINGLE MOTHERS

DEFINITION: This indicator reflects births by women who were not married to the child's father at the time of the event and had not been married to him at any time during the preceding ten months.

Locality refers to the mother's reported residence.



Children who are born to single women are considerably more likely than children born to two parents to grow up poor, to spend large portions of their childhood without two parents, and to become single parents themselves.

Research indicates that poor single parents tend to be more punitive, inconsistent, and unresponsive in interacting with their children than are other parents. The impacts of such parenting often show up as learning disabilities, psychological problems, and behavioral disturbances in children.[9]

Children born outside of marriage are nearly twice as likely to be poor than those born to married parents.[10] This is particularly relevant in Virginia, where nearly one of three children is born to a single parent.

Babies born to unmarried mothers are at higher risk of having adverse birth outcomes, such as low birth weight and infant mortality, because their mothers are less likely to have received prenatal care, less likely to have gained sufficient weight while pregnant, and more likely to have smoked during pregnancy.

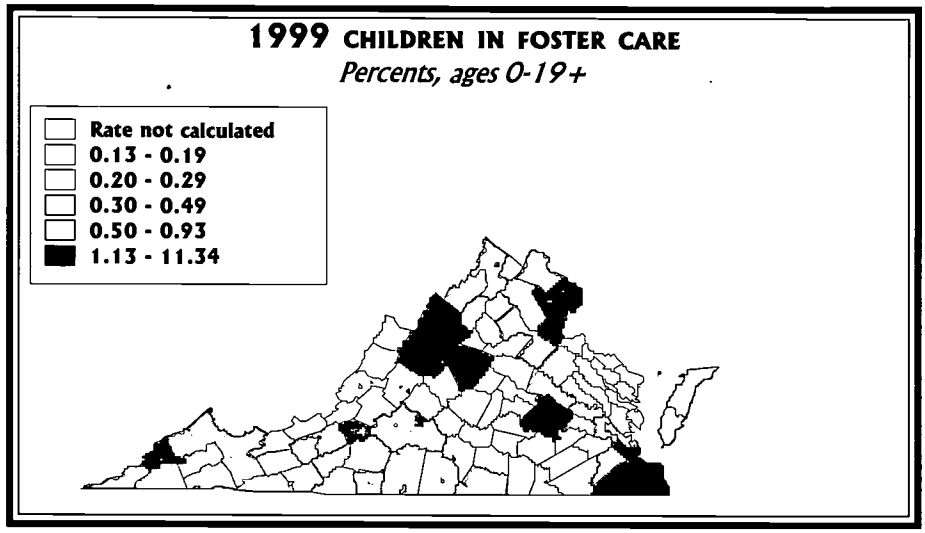
CALCULATION FOR RATES: (the number of births to single mothers/total number of live births) x 100

SOURCE OF RAW DATA: Virginia Department of Health

CHILDREN IN FOSTER CARE

DEFINITION: This indicator includes children on runaway status, those in a trial-home placement, those living in their own homes, and those children in out-of-home placements.

A child is placed in foster care when authorities determine that his or her family cannot provide a minimally safe environment.



Both federal and state laws discourage removal of children from their families unless it is necessary to ensure the child's safety, so out-of-home placement in foster care is an extreme step taken only when a child is in immediate danger or when attempts to help the family provide a safe environment have failed.

Children who are placed in foster care often have special health needs, due to their pre-placement family lives; *Pediatrics* magazine reports that these children frequently have high rates of vision problems and exposure to tuberculosis.

According to the Virginia Department of Social Services, the primary reason Virginia's children are placed in foster care—either a foster home or a residential setting—is the presence of abuse or neglect.

This indicator is a gauge for extreme family dysfunction, and how well-equipped a community is to attend to the needs of very vulnerable children.

CALCULATION FOR RATES: The rates (percentages) for this indicator were supplied and defined by the Virginia Department of Social Services.

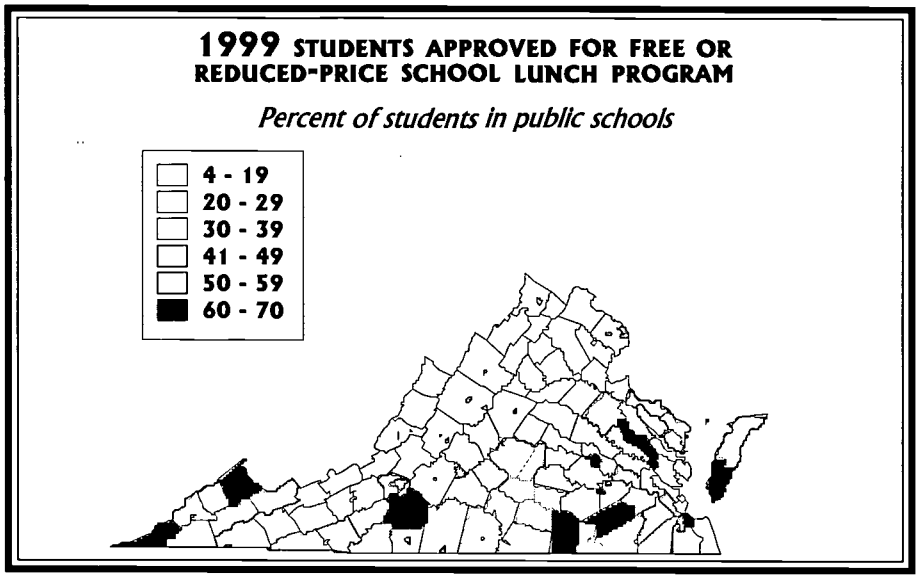
SOURCE OF RAW DATA: Virginia Department of Social Services

ECONOMY

Economic factors affect young people. It has been shown that negative outcomes for children can often be traced to poverty or to inadequate economic conditions. Generally, children are not economically responsible for themselves; rather, they live in families and communities that vary in their access to economic and social resources. Because children are dependent on others, many of their experiences are directly related to the economic well-being of their families and/or communities. By examining the information in this cluster of indicators—students approved for free or reduced-price school lunch program, children receiving Temporary Assistance for Needy Families, unemployment rate, and average per capita income—Virginians can assess whether or not their communities' economic health supports the well-being of children.

Virginia-specific locality data for each of these indicators is available online. Accessing this data requires a one-time logon fee. For more information, visit the Action Alliance web site (www.vakids.org - & click on "KIDS COUNT") or telephone the Action Alliance at (804) 649-0184.

STUDENTS APPROVED FOR FREE OR REDUCED-PRICE SCHOOL LUNCH PROGRAM



DEFINITION: This indicator shows the number of Virginia public school students who were approved for free and reduced-price school lunches.

Because poverty is not measured annually on a locality basis in Virginia, and because the criteria for being approved for this program relate to living near the poverty line, this indicator is often used to approximate the percent of young Virginians living in poverty.

The children who qualify for this program are more likely to live in families where there is not enough money to purchase a balanced diet that ensures proper nutrition for growing children, so this may in turn affect adversely children's good health and development.

In Virginia, about 1 in 3 rural students are eligible for free school lunches, compared to 1 in 4 non-rural students.[11]

Some Virginia public schools do not participate in this program and therefore do not report any data.

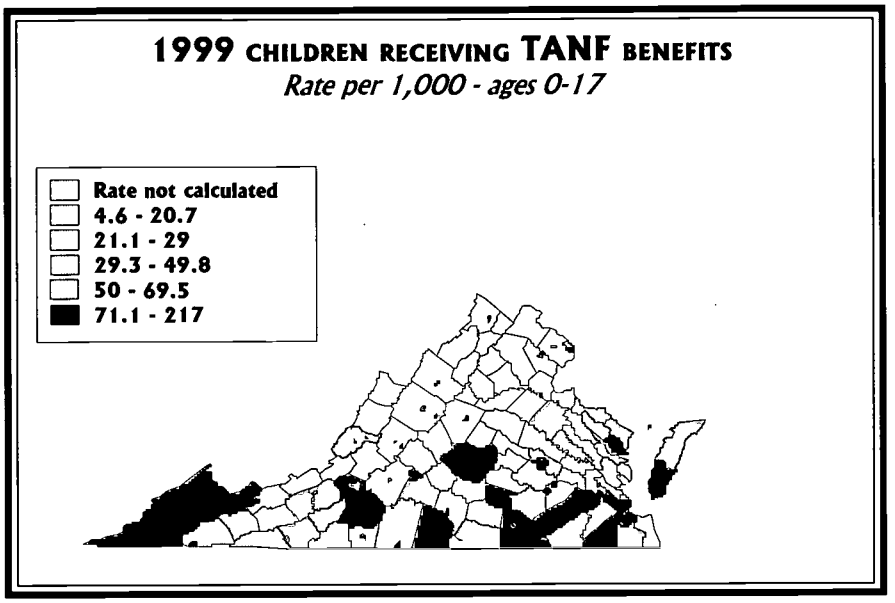
CALCULATION FOR RATES: The rates (percentages) for this indicator were supplied by the Virginia Department of Education.

SOURCE OF RAW DATA: Virginia Department of Education

CHILDREN RECEIVING TANF

DEFINITION: This number represents a monthly average of Virginians ages 0-17 who are receiving Temporary Assistance to Needy Families, a federally mandated block grant cash assistance program.

Statistics are a monthly average of children receiving TANF benefits.



A result of major welfare reform, Temporary Assistance to Needy Families (TANF) was enacted in the 1990s; it abolished the 60+ year-old Aid to Families with Dependent Children (AFDC). Under the welfare law, each state must require a parent or caretaker receiving TANF assistance to work (as defined by the state) once the person has been determined to be ready for work, or once the person has received assistance for 24 months.

Many poor children depend on public assistance for their basic material needs. Children receiving government assistance are the poorest of poor children. Studies have found that children who have increased exposure to governmental assistance programs tend to score lower on tests and to exhibit more behavior problems than other children.[12]

This is an example of a governmental program that was established to help those in poverty; however, studies reveal that even a full range of welfare benefits—including AFDC/TANF, food stamps, Medicaid, and housing subsidies—typically meet only three-fifths of a family's needs, and that resources for adequate food, clothing, and other necessities are often lacking.[13]

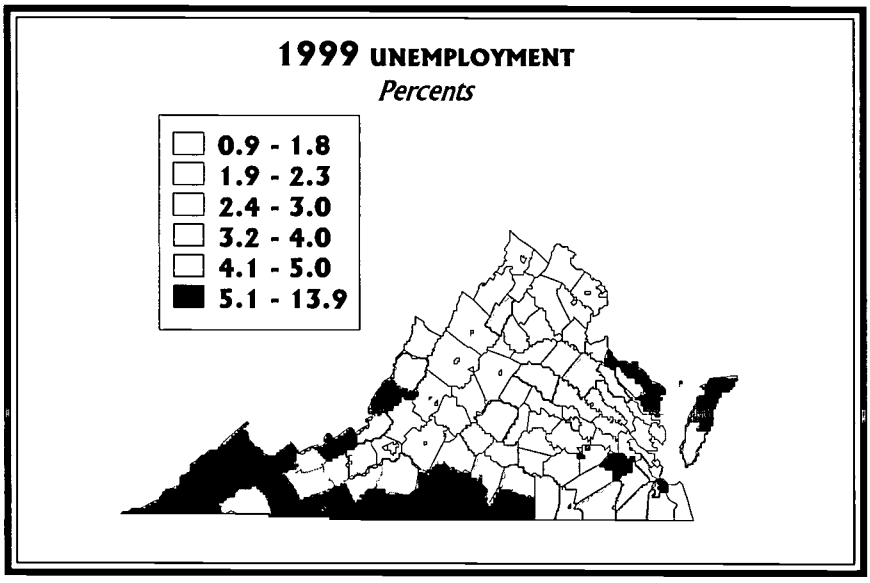
The rate of children receiving assistance provides important information about the percentage of children whose current life circumstances are hard and whose futures are potentially limited as a result of their family's low income.

CALCULATION FOR RATES: (children receiving TANF assistance/population, ages 0-17) x 1,000

SOURCE OF RAW DATA: Virginia Department of Social Services

UNEMPLOYMENT RATE

DEFINITION: The unemployment rate represents the number of unemployed people in a locality and reflects joblessness among those actively looking for work.



Unemployment is a key indicator of economic health. The lower the unemployment rate, the better the job climate for workers.

The unemployment rate measures the opportunities available to families, but it may not encompass all facets of employment opportunities for adults in low-income families. Data on unemployment do not reflect the extent of under-employment, which includes those who work part-time because full-time work is unavailable, and those who are "discouraged" and not looking for work.

Employment is not a guarantee that families—particularly those with low-wage earners—will avoid poverty. Reports issued in 2000 found that nearly one-third of poor families in Virginia were not able to escape poverty, despite being employed in a year-round, full-time job, and that nearly 45% of jobs in Virginia pay below the poverty guidelines, resulting in growing numbers of working poor families, which account for about 159,000 children in the Commonwealth (based on a mid-1990s estimate).[14]

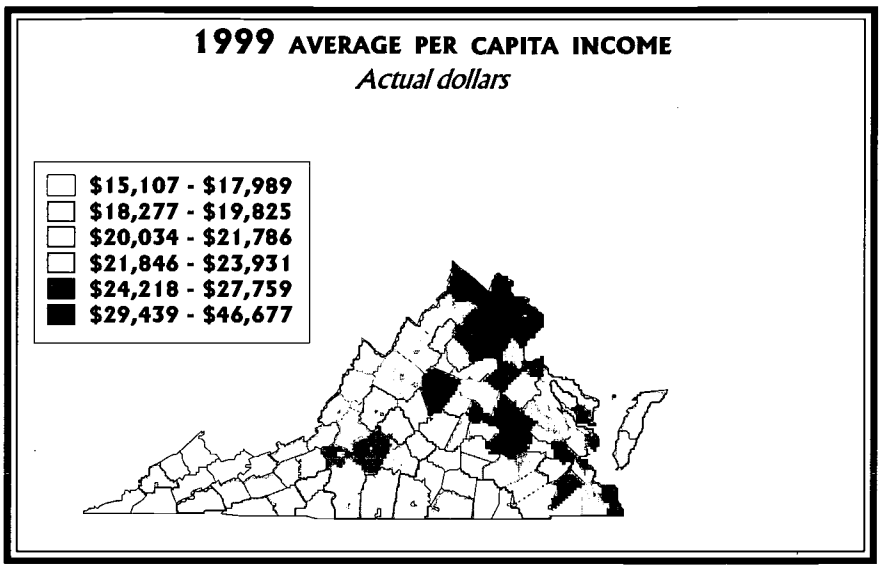
CALCULATION FOR RATES: (the number of unemployed persons actively looking for work/total civilian labor force) x 100

SOURCE OF RAW DATA: Virginia Employment Commission, Bureau of Economic Analysis

AVERAGE PER CAPITA INCOME

DEFINITION: This category represents average income per person—including pay for full-time and part-time work and benefits such as retirement and public assistance.

Measuring income is a good way to assess the economic well-being of children, as it reflects the ability of the parent to purchase food, shelter, clothing, child care, and other basic goods and services required to raise children.



A family's income is a powerful predictor of children's outcomes. Two large, longitudinal studies showed that family income strongly predicted children's vocabulary, IQ, reading, and math skills.[15]

Are Virginia families earning enough money to live, or for instance, to cover the cost of a basic necessity, such as shelter? According to *Out of Reach*, a September 1999 report by the National Low Income Housing Coalition, in Virginia, a worker earning the minimum wage (currently $5.15 an hour) would have to work 92 hours per week in order to afford a two-bedroom apartment, at the Commonwealth's fair market rent of $618 per month for such a unit*. They determine that the housing wage (the amount a worker would have to earn per hour in order to be able to work 40 hours per week and afford a two-bedroom apartment) in Virginia is $11.88 per hour, which is 231% of the current federal minimum wage. The report concludes that more than half of the renters in Virginia are unable to afford fair market rent for a two-bedroom unit, based on the Commonwealth's 1999 estimated renter household income of less than $23,000.

**Fair market rent for a one-bedroom unit in Virginia is $522. More information from this report is available online at www.nlihc.org/cgi-bin/data.pl?getstate=on&state=VA.*

CALCULATION FOR RATES: No rates are calculated; actual gross income is reported.

SOURCE OF RAW DATA: Virginia Employment Commission, Labor Market and Demographic Analysis

References/sources for the preceding text are on pages 50-51.

Some notes (about the data on pages 8 - 29):

Data from 1999 were selected for this project because, as of February 2001, many indicator and demographic data were not available for any time period later than 1999.

The demographic data for this project (used to calculate rates in the data graphs in this book and in locality-level data on the Internet database) were supplied by the US Census Bureau. The numbers are estimates, based on the 1990 decennial census. Information this detailed in nature will not be available from the 2000 decennial census survey (which was conducted in April 2000) until later in 2002. For more information, visit the Census Bureau's web site (www.census.gov) or call them at 301-457-4100.

For all indices for all years, measures describing South Boston city were combined with measures describing Halifax County.

For the indices of prenatal care, low birth-weight babies, teen births, and births to single women, the measures describing the following cities: Blacksburg/Christiansburg, Front Royal, Herndon/Vienna, and Leesburg were combined with measures describing the counties of Montgomery, Warren, Fairfax, and Loudoun, respectively.

In calculating rates for child care availability, some localities—when calculated alone—had rates greater than 1,000 per 1,000. For this reason, their data were combined with that of neighboring localities (with whom they are traditionally associated), to achieve a truer rate. This was done with Fairfax County, which was combined with Fairfax city and Falls Church for this indicator; and for James City County, which was combined with Williamsburg for this indicator.

The Virginia Department of Education school division codes do not match exactly the FIPS locality codes (used in this data project and standardly by many data-reporting agencies in the Commonwealth). To provide comparability across all indices, the following conventions were applied to data provided by the Department of Education:

- Data for Colonial Beach were combined with data for Westmoreland County.
- Data for West Point were combined with data for New Kent County.
- Data for the joint district of Alleghany Highlands & Clifton Forge were repeated for each community.
- Data for the joint district of James City County & Williamsburg were repeated for each community.
- Data for the joint district of Fairfax county & city were repeated for each community.
- Data for the joint district of Bedford county & city were repeated for each community.
- Data for the joint district of Emporia & Greensville County were repeated for each community.

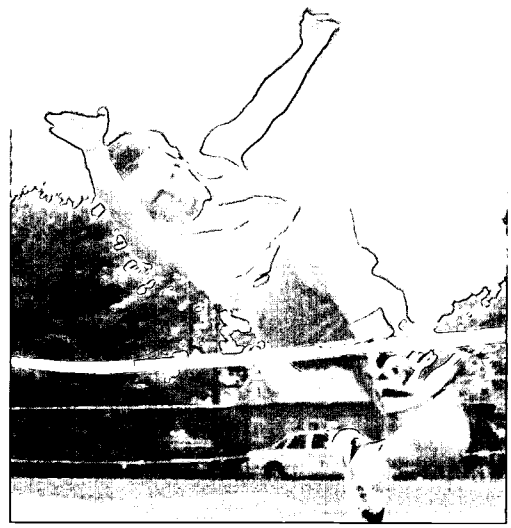
These conventions resulted in 135 localities, albeit with the duplicates described above, and these 135 localities were then ordered by quintile rank (in the cases where the number of occurrences was 10 or greater).
For this project, the Department of Education provided data on: 9th-12th graders who dropped out of school, students promoted in K-3, students eligible for special education services, and students approved for free or reduced-price school lunch program.

SPECIAL TOPICS

Some issues—for which annual locality data may not be available in Virginia—are important factors in examining the well-being of our young people. Some of these topics are discussed here, including

- **Early Care and Education**
- **Children's Mental Health**
- **Prevention of Violence**
- **Injuries and Children**
- **Developmental Disabilities**
- **Poverty**
- **Other Issues**

tobacco usage, nutrition and exercise, HIV/AIDS, dental health, substance abuse, insurance, homelessness, and family stress and turbulence



Early Care and Education

Investments made in the first five years of a child's life significantly impact later development—such as lowering the risks of academic problems, school dropouts, delinquency, and teenage pregnancies. Because the majority of parents today are in the work force, critical questions arise about the care that these young children receive—in terms of quality, affordability, and accessibility.

Child care is essential for most working families. And, care received during formative years is the foundation for a child's education; it allows our youngest children to begin to develop the fundamental skills to become productive workers and citizens.

Does the current child care system meet the needs of our families and children? High turnover rates among child care staff, long waiting lists to receive child care, and the many barriers to accessing quality child care suggest that the answer is negative.

High staff turnover rates plague the child care field. Estimates are that 35-45% of staff leave child care each year, with low compensation being the primary reason for leaving. In Virginia, in 1998, the median hourly wage paid to child care staff was about half of that paid to all other workers, garnering the Commonwealth a last-place ranking among the 50 states.[16] The quality of care and benefits that children receive unquestionably are tied to a sustained relationship with a caregiver, so frequent turnover hurts children. The subsequent effects are far-reaching: not only are children and their families affected, but there is also a potential negative impact on productivity and turnover of individual working parents, future business growth and profitability, and local economies.

Resources for child care in the Commonwealth are insufficient to meet the need, resulting in waiting lists of low-income working families. Being placed on a waiting list has been shown to increase the likelihood of a family going on welfare, developing debts that threaten bankruptcy, or being unable to maintain employment because of unstable child care arrangements.

There are many barriers to accessing child care in the Commonwealth. A major obstacle is cost. On average, child care is the third largest expense after housing and food for all families with preschool age children. The Urban Institute reported in December 2000 that nearly half of America's working families with a child under age 13 have child care expenses that consume on average nine percent of their monthly earnings; working low-income families, single parents, and families with younger children spend a considerably higher share of their earnings on child care. They also found that, although the average dollar amount that a family spends on child care varies across states, the share of earnings that a family spends does not. A 1998 Virginia survey found widespread problems with the availability of quality child care; when such a program is located, its cost often makes it inaccessible to the average worker in the community. In Virginia, the average cost of one year of child care for an infant or toddler is greater than the average cost for one year's tuition at Virginia's four-year colleges and universities.

Finding child care for "non-traditional" working hours (such as evening/overnight shifts and weekends) is also very difficult; however, these hours are required of many working parents who must seek care for their children. This is especially true for parents in low-income jobs, newly entering the labor market. Locating suitable child care quickly can be a problem. Studies show that it takes two to seven weeks for parents to conduct a thorough search for child care. However, when a job becomes available, lower-wage workers must be able to take it almost immediately, even though such low-income parents are rarely able to afford to pay for child care before they have a job in hand.

And, transportation issues figure significantly in Virginia's problems with accessibility to child care. Many low-income parents must travel long distances to get to work or child care. This is compounded by geographic features such as mountains in western Virginia and lots of water in the east, and also by the fact that public transportation is not available in most rural areas of the Commonwealth.

Receiving quality child care remains elusive for many children. Numerous studies demonstrate that vulnerable children benefit from high-quality early intervention programs, but often this is not what the most needful children get. In the mid-1990s, a General Accounting Office study found that more than half of low-income children attend early childhood centers that fail to provide the full range of child development, health, and parent services needed to support their school readiness. Simply put, child care that is not stimulating and supportive may create more problems for low-income preschoolers, who already face many obstacles to success.

Working for affordable, accessible quality child care is a priority focus of the Action Alliance for Virginia's Children and Youth. Among its activities in this area are: the production of a series of white papers on critical issues in child care in Virginia; the development and maintenance of a statewide coalition of individuals and organizations committed to securing quality child care for young people in the Commonwealth; and the coordination of the TEACH-VA (Teacher Education and Compensation Helps) project, which provides scholarships to child care staff to enhance their education, and subsequently, their compensation. Information about the white papers, the Quality Child Care Coalition, or TEACH-VA is available at the Action Alliance's web site (www.vakids.org) or by calling (804) 649-0184.

The chart below summarizes the closures and complaints received and investigated by the Virginia Department of Social Services in fiscal years 1998 - 2000.

Closures and Complaints for Virginia Child Care Centers, Fiscal Years 1998-2000

Following is a summary of closures and complaints for child care centers in the Commonwealth, according to the Virginia Department of Social Services.

	FY98	FY99	FY00
Closed Child Day Care Centers	149	154	147
Ceased Operation	136	146	133
Renewal Application Denied	2	Not Available	1
Licenses Revoked	1	1	1
Number of Complaints Received	813	983	1,023
Number of Complaints Found Valid	457	551	590

Children's Mental Health

Mental health refers to how children function psychologically on a day-to-day basis—how they think, feel, and act. The way they relate to others, feel about themselves, handle stress, and make choices are important components of mental health. It is helpful to think of mental health, like physical health, along a continuum. There are varying degrees of wellness and problems across the spectrum of mental health. And the degree of wellness or illness can vary over time—many children and adolescents experience mental health problems at some point during their growing-up years.[17]

A child or adolescent with mental health problems often has difficulty functioning at home, in school, or in the community. The child's problems also have an impact on the people around him or her—parents, siblings, and peers. Some parents cannot work because they are taking care of their children with mental illness; they do not have access to day care that is equipped to deal with their child's problems. Inordinate time spent caring for the child with emotional or behavioral problems means less time to spend with other children in the family.

Untreated mental illness in children and adolescents has dire consequences. Alarmingly, an estimated two-thirds of children with mental health disorders are not getting the treatment they need.[18] According to the National Institute of Mental Health, children with untreated emotional and cognitive disorders are at risk for school failure and dropping out, violence, and risky behaviors, including the risk of HIV transmission.[19] Drug abuse, suicide, and criminal activity are additional results of untreated disorders.[20] In Virginia, 73% of students with serious emotional handicaps do not complete high school.[21] National statistics show that nearly three-quarters of these dropouts are arrested within five years of leaving school.[22]

Mental health problems occur in children of all races, socio-economic levels, and backgrounds, but there are certain factors that increase risk for mental disorders. Research shows that the causes of children's mental health problems are a factor of both the child's own characteristics, such as genetic and biological factors, and the child's environment, including parents, siblings, peers, and the neighborhood or larger community.[23]

Biological risk factors include genetic risks—particularly for illnesses such as depression, autism, bipolar disorder, and schizophrenia—as well as biological abnormalities of the central nervous system, which can be caused by injury, infection, exposure to environmental toxins, and poor nutrition.[24] Prenatal exposure to alcohol, drugs, and cigarette smoke; traumatic brain injury; and malnutrition during pregnancy are all well-researched biological factors that have negative impacts on children's mental health.

Distressing childhood experiences also can create environmental risk factors for children. Dysfunctional family life, economic hardship, exposure to violence—both in the community and in the home—and poor parental attachment can all put children at greater risk for developing mental health disorders.[25] Child abuse and neglect have been linked to a variety of disorders, including depression, post-traumatic stress disorder, and conduct disorder.[26]

It is estimated that almost 21 percent of children in the US ages 9 to 17 have a diagnosable mental or addictive disorder with at least minimal impairment. Eleven percent of children experience significant impairment, and 5 percent experience extreme impairment. In raw numbers, an estimated four million children in the US experience a major mental illness that significantly affects their ability to function.[27]

This essay and the fact sheet on the opposite page were condensed from Issues in Children's Mental Health, *a special report produced by the Action Alliance in October 2000. The report is available online (www.vakids.org & click on "KIDS COUNT").*

Children's mental health is a priority focus of the Action Alliance, who has formed a statewide coalition that addresses this important issue. More information is available on the Action Alliance web site (www.vakids.org) or by calling 804-649-0184.

CHILDREN'S MENTAL HEALTH: SOME FACTS

Virginia loses one adolescent a week to suicide.

- Suicide is the third leading cause of death for young people in the Commonwealth.
- Boys ages 15-19 are about four times more likely to complete suicide than girls their age, although girls are twice as likely to attempt suicide.
- A gun in the home increases the risk of suicide in adolescents about four-fold; a handgun in the home increases the risk nine-fold.

Access to mental health care is a problem for many young Virginians.

- Only 64 public hospital beds are available in Virginia to serve seriously emotionally disturbed children with no insurance, those whose behavior is so severe that private inpatient providers refuse to serve them, and those in custody of juvenile justice.
- Community service boards in Virginia do not have the resources to serve all children in need of mental health services; estimates are that about 4,000 needy young people are either receiving no services or inadequate services.
- Parents sometimes must relinquish custody of their children (usually to governmental agencies) in order to access mental health treatment for them.
- Only 6.9% of the total funds allocated by the Commonwealth for mental health services are required to be spent on services for children.

Virginia's juvenile justice system is often used as a "dumping ground" for children and youth with mental health problems.

- Roughly half of the youth who are incarcerated in Virginia have designated mental health needs.
- Some youth are shuttled back and forth between the mental health and juvenile justice systems, leaving them with fragmented and sometimes inadequate treatment.

Prevention of Violence

Children need to feel safe.

However, the US is the most violent country in the industrialized world, having the highest numbers of homicides, rapes, and assaults. The problem of violence is not restricted to any one group or area. All children today are affected by the violence that spreads throughout the nation, the Commonwealth, our communities, and our homes. Violence threatens the healthy development of children.

Youth violence takes many forms. It ranges from aggressive verbal assaults to physical harm to death.

The victim or the perpetrator (or both) may be a young person. Outcomes, severity, and causal factors may differ. Not all children respond to difficult situations in the same way. Figuring prominently in youth violence are the perpetrator's age and developmental level, temperament, community environment, family dynamics, and social and learning experiences. There is no single reason or cause for violent behaviors.

Some children experience violence more directly than others, but every child feels the effects of violence. Exposure ranges from encountering strong images and messages in the media to being a direct witness, victim, or perpetrator.

Although violence and its symbols are pervasive in our culture, violence is not inevitable. It is a learned behavior in response to stress. We all have some potential for violent behavior; we have observed others using violence and know how to do it.

Young people who commit violent offenses often have many simultaneously-existing problems in their lives. The presence of these problems—such as peer pressure, need for attention, feelings of low self worth or of isolation, early childhood abuse or neglect, witnessing violence (at home, in the community, or in the media), and easy access to weapons[28]—does not cause violence to occur; it just increases the likelihood that violence will result.

At an early age, children often learn aggression is an effective way to deal with conflict. According to research, it is possible to predict from an eight-year-old's aggressive behavior in school how aggressive that child will be in adolescence and adulthood—including whether he or she will exhibit criminal and antisocial behavior.[29]

> By the age of 18, the average child will have seen 40,000 killings and 200,000 acts of violence on television. - *American Medical Association*

Another influence that often affects a child's tendency toward violent behavior is media violence—in the form of television, movies, music videos, or video games—that he or she is exposed to. A study found that "viewing violence in the media can lead to increased violence toward others, increased fearfulness about becoming a victim of violence, increased callousness toward violence among others, and increased self-initiated behavior that exposes

one to further risk of violence."[30] A primary complaint about media violence is that it rarely depicts the harmful and lasting consequences of real-life violence.

The earlier a child begins to commit violent offenses, the greater likelihood he or she will continue to do so. Studies have found that about 50% of children who begin committing violent offenses before the age of nine become chronic violent offenders during adolescence, compared with about 40% who begin committing violent offenses between the ages of 10 and 12, and 23% who began at age 13 or older.[31]

In addition to the above-named risk factors for children engaging in violent behaviors, substance abuse plays a critical role in the occurrence of violence. The use or abuse of various substances can impair judgement, reaction time, and inhibitions, which can lead to conflict or violence; it can shape an encounter so that the outcome is different than if one or both parties were sober. This increased likelihood of committing violent acts can lead to being jailed, which is particularly relevant in the Commonwealth—a 1999 report stated that more than one-half of juvenile offenders incarcerated in Virginia had previous substance abuse problems.[32]

Exposure to multiple forms of violence at home—including domestic violence, child abuse, and a general family climate of hostility—doubles the risk of self-reported youth violence.[33] Studies have shown that children who witness and/or experience violence may suffer developmental or motor disorders, exhibit problem behaviors such as aggression and social incompetence, or become violent themselves.[34]

> Fewer than 1% of all homicides among school-aged children occur in or around school grounds. - *Centers for Disease Control & Prevention*

Violence committed at schools is often at the forefront of news. However, according to the Centers for Disease Control and Prevention, fewer than 1% of all homicides among school-aged children occur in or around school grounds or on the way to and from school. To put this issue into perspective, the Justice Policy Institute reports that the number of children killed by gun violence in schools is about half the number of Americans killed annually as a result of being struck by lightning. Yet, about 13 children are killed each day by guns—in non-school settings.

A comprehensive, integrated approach is necessary to more effectively reduce violence. Some factors have been shown to lessen the likelihood of violence, including early care and education and after-school care; strong and supportive adults in family, schools, and the community; parental monitoring of media in the home; and restricted availability to weaponry.

As concerned Virginians. we must advocate for public policies and actions to reduce violence and its causes. We must focus energy and resources on prevention, rather than intervention. A generation is at risk.

This essay was excerpted from An Overview: Children and Violence, *a special report produced by the Action Alliance. The report is available online (www.vakids.org & click on "KIDS COUNT").*

The prevention of violence is a priority focus of the Action Alliance. who has formed a statewide coalition to address this important issue. More information is available online (www.vakids.org) or by calling 804-649-0184.

Injuries and Children

If some infectious disease came along that affected children [in the proportion that injuries do], there would be a huge public outcry, and we would be told to spare no expense to find a cure and to be quick about it. – *Former Surgeon General C. Everett Koop*

Injuries kill more children in Virginia than all other causes of death combined. On average, one child dies each day in Virginia, as a result of injuries. Nationally, the number is closer to 37 child deaths each day, due to injuries.

What types of injuries claim the lives of these children in Virginia? The leading causes of death for Virginians under age 20 are: motor vehicle crashes, firearms, suffocation, drowning, fire and burns, and poisoning. Most of these injuries are unintentional* but are preventable** and predictable.

Injuries do not discriminate in terms of which child or family they affect. Unintentional injuries are the leading cause of death for all children older than one year, but more than half of all unintentional injury deaths happen between the ages of 15 and 19.

Nearly 70% of injury deaths among Virginians ages 0-19 are due to motor vehicle crashes and to firearms. The Commonwealth's most likely victims of motor vehicle crashes and firearms are adolescent males, ages 15-19.

Deaths only partially convey the enormous public health impact caused by childhood injuries. Injuries can also result in hospitalizations for young people. Many of these nonfatal injuries result in disabilities. It is estimated that for every fatal injury, approximately 18 children are hospitalized and 233 are treated in emergency departments for nonfatal injuries. Studies show that nonfatal firearm injuries treated in hospital emergency departments outnumber firearm fatalities nearly 3 to 1.

Each year, 1 in 5 American children receives medical care as a result of injury. In 1997, each day, on average, more than 14 Virginians under the age of 20 were hospitalized as a result of injury. The Commonwealth's estimated cost for this was more than $36 million.

Certain factors increase the likelihood of injuries occurring. Some of them are: alcohol-impaired drivers (in motor vehicle crashes); not using standard protective gear properly (such as bicycle helmets, seat belts, or child safety seats); and limited resources for education and public awareness campaigns.

Injury impacts the lives of everyone in the Commonwealth. Serious injuries rob children of their health and lead to more child deaths and permanent disabilities than all diseases combined. Most unintentional injuries can be prevented through education, environment and product changes, and legislation or regulation.

---

* In the mid-1990s, unintentional injuries—such as motor vehicle or bicycle crashes, drownings, and fires—accounted for 65 percent of all injury deaths. Intentional injuries—results of purposeful acts of harm, such as homicides and suicides—were responsible for about 33 percent of all injury deaths. Injuries of undetermined intent accounted for the remaining 2 percent.

**It is estimated that more than 4,000 childhood injury deaths—and nearly 20 times that number of serious nonfatal injuries—could have been prevented in 1996 alone.

Sources for this essay:

Unintentional Injuries in Childhood, *The Future of Children*, Vol 10, No 1 - Spring/Summer 2000. David and Lucile Packard Foundation.

Childhood Injury in Virginia 1994-1997, produced by the Center for Injury & Violence Prevention, of the Virginia Department of Health

Pediatric Morbidity and Mortality for the State of Virginia in 1997, produced by the Virginia Emergency Medical Services for Children program.

1997 Deaths Related to Motor Vehicle Traffic and to Firearms in Virginia, among ages 0-19, by EMS Region

EMS Region	Motor Vehicle Traffic Deaths		Firearm-Related Deaths	
	Reported Occurrences	Rates per 100,000*	Reported Occurrences	Rates per 100,000*
Blue Ridge	7	12	2	3
Central Shenandoah	9	14	3	5
Lord Fairfax	6	13	1	2
Northern	16	4	12	3
Old Dominion	39	13	51	17
Peninsulas	13	9	6	4
Rappahannock	6	6	2	2
Rappahannock-Rapidan	7	22	0 reported	--
Southwest	11	11	5	5
Thomas Jefferson	5	10	1	2
Tidewater	19	6	24	7
Western	22	13	7	4
VIRGINIA TOTAL	**160**	**9**	**114**	**6**

Localities in Each EMS Region: **Blue Ridge** - Amherst, Appomattox , Bedford, and Campbell counties; Bedford and Lynchburg cities; **Central Shenandoah** - Augusta , Bath, Highland, Rockbridge, and Rockingham counties, and Buena Vista, Harrisonburg, Lexington, Staunton,and Waynesboro cities; **Lord Fairfax** - Clarke, Frederick, Page, Shenandoah, and Warren counties, and Winchester city; **Northern** - Arlington, Fairfax, Loudoun, and Prince William counties, and Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park cities; **Old Dominion** - Amelia, Buckingham, Brunswick, Charlotte, Charles City, Chesterfield, Cumberland, Dinwiddie, Goochland, Greensville, Halifax,Hanover, Henrico, Lunenburg, Mecklenburg, New Kent, Nottoway, Powhatan, Prince Edward, Prince George, Sussex, and Surry counties, and Colonial Heights, Emporia, Hopewell, Petersburg, and Richmond cities; **Peninsulas** - Essex, Gloucester, James City, King & Queen, King William, Lancaster, Mathews, Middlesex, Northumberland, Richmond, Westmoreland, and York counties; Hampton, Newport News, Poquoson, and Williamsburg cities; **Rappahannock** - Caroline, King George, Spotsylvania, and Stafford counties, and Fredericksburg city; **Rappahannock-Rapidan** - Culpeper, Fauquier, Orange, and Rappahannock counties; **Southwest** - Bland, Buchanan, Carroll, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe counties, and Bristol, Galax, and Norton cities; **Thomas Jefferson** - Albemarle, Fluvanna, Greene, Louisa, Madison, and Nelson counties, and Charlottesville city; **Tidewater** - Accomack, Isle of Wight, Northampton, and Southampton counties, and Chesapeake, Franklin, Norfolk, Portsmouth, Suffolk, and Virginia Beach cities; **Western** - Alleghany, Botetourt, Craig, Floyd, Franklin, Giles, Henry, Montgomery, Patrick, Pittsylvania, Pulaski, and Roanoke counties, and Clifton Forge, Covington, Danville, Martinsville, Radford, Roanoke, and Salem cities.

Data provided by Emergency Medical Services for Children program.

*Most of the reported occurrences for each region are less than 20. Because rates based on numbers this size can create a false impression, the Centers for Disease Control and Prevention recommend not calculating incidence rates for fewer than 20 occurrences. To ensure a better understanding of this information, the raw numbers for each region should be considered.

Petra Menzel of the Virginia Emergency Medical Services for Children program provided assistance in the preparation of this essay.

*For more information on injury prevention or on increasing injury awareness, contact the Center for Injury and Violence Prevention, Virginia Department of Health, 1500 E Main St, Rm 105, Richmond, VA 23218-2448, 1-800-732-8333, **OR** the Virginia Emergency Medical Services for Children program, Virginia Commonwealth University, PO Box 980107, Richmond, VA 23298, 804-628-EMSC, www.vdh.state.va.us/oems/emsc.*

Developmental Disabilities

Children who experience developmental disabilities or delays—due to autism, brain injury, cerebral palsy, epilepsy, learning disabilities, mental health disorders, mental retardation, problems associated with speech and hearing, spina bifida, Tourette Syndrome, and visual impairments—are likely to be affected negatively by many of the risk factors outlined in this data project. These young people are especially vulnerable when they have not received adequate special education and related services. This essay examines some basic information about children with developmental disabilities—including some risk factors, an overview of community supports available, and some possible outcomes, including interaction with the juvenile justice system.

The federal government recognizes that many children are in need of specialized supports and services because they experience developmental delays or disabilities. These specialized supports and services are available at the community level through IDEA (Individuals with Disabilities Education Act), which provides for Virginia children under the age of five (who are developmentally delayed or disabled). It is important to note that formalized programs—such as IDEA—only support the development of children with identified developmental delays or disabilities, and that they do not reflect the needs of young children who are at risk for developmental concerns due to social, health, or environmental factors.

In the Commonwealth, other community supports are available for specific populations of children in need. For example, in most, but not all, Virginia localities, Head Start programs* provide a variety of early childhood educational and enriching experiences and education for some low-income children and their parents; and the Virginia Preschool Initiative (VPI) provides educational services for some four-year-olds who are at risk of school failure. The programs are usually part-day, part-year programs and, therefore, generally do not meet families' needs for child care.

Challenges remain in reaching eligible infants and toddlers as early as possible through public awareness efforts and then linking them with needed supports and services, specialized training for staff in working with disabled young children, ensuring quality programming, and making sure necessary and adequate financial and administrative support are available.

Encouragingly, at the community level across Virginia, there is increasing collaboration among local education agencies, Head Start, and VPI programs to provide services for children who are developmentally disabled. However, many of these types of services are provided in segregated settings, not allowing an opportunity for interaction with typically-developing peers, and vice versa.

An overview of developmental disabilities would be incomplete without an examination of the significant role played by child abuse and neglect. Maltreatment has been shown to lead to developmental disabilities in children, and also to be more likely to occur if a child has a disability.

Physical abuse is the most common cause of serious brain injury in children younger than one year; and about 25% of serious brain injury is the result of child abuse. Almost half of all children who survive inflicted brain injury are thought to have mental retardation. More than half of infants who survive shaken baby syndrome become children with severe disabilities.[35]

Having a disability tends to increase a child's likelihood of being abused or neglected. Research shows that fewer than 1 in 10 non-disabled children are maltreated, while nearly 1 in 3 disabled children are, with neglect being the primary form of maltreatment, followed by physical, emotional, and sexual abuse. Children with disabilities tend to be abused or neglected at younger ages.[36]

In addition to abuse, research shows that environmental factors can present hazards to the development of our young. For instance, lead poisoning is the leading environmental hazard to children, making it a significant public health concern. Some factors that increase a child's risk of being poisoned by lead are: living in or regularly visiting a house or day care center built before 1950, being around chipping paint or renovations (to a facility built before 1978), and living near an industry site likely to release lead (such as a lead smelter or a battery recycling plant). Young children under the age of six are at a greater risk for lead poisoning because of their hand-to-mouth activity. In the US, nearly 900,000 children are estimated to have lead poisoning; in Virginia, about 25,000 children are lead poisoned, and, although the numbers have been declining, an estimated 500 new cases are seen each year.[37]

Youth with disabilities, especially learning disabilities and disorders related to attention-deficit and mental health, tend to be over-represented in the juvenile justice system nationwide. This is true for the Commonwealth, also—between 1993 and 1998, approximately 40% of youth committed to the Department of Juvenile Justice were identified to be eligible for special education services prior to and/or at the time of encounter with the justice system. Issues related to learning disabilities are one of the most frequently identified special education needs for these youth.[38] Researchers hypothesize that learning-disabled youth are entering the juvenile justice system because student misconduct in school is becoming increasingly criminalized,[39] which may result from inappropriately-trained personnel misinterpreting a youth's specific disability as solely a behavioral problem.

Although there are some successful efforts within the Commonwealth to provide the necessary services and supports for developmentally disabled youth, Virginia lacks a comprehensive strategy—that integrates education, juvenile justice, and mental health services—to address the needs of this very vulnerable population.

---

* Head Start is required, by federal regulation, to reserve at least 10% of available slots for children with disabilities.

Research and assistance for this essay were provided by the Virginia Institute for Developmental Disabilities, 700 East Franklin Street, PO Box 843020, Richmond, VA 23284-3020, 804-828-3876,http://www.vcu.edu/vidd. A more comprehensive essay and other related information are on the 2001 KIDS COUNT in Virginia online database.

Poverty

Poverty is defined as lacking many goods and services considered essential to human well-being. It is estimated that 1 of 5 children live in poverty nationally, and almost that many live in poverty in the Commonwealth.[40]

Children are not wealthy or poor by themselves, rather they live in families that vary in their access to economic and social resources. Because children are dependent on others, they enter or avoid poverty by virtue of their family's economic circumstances.

Although many stereotypes go along with our notion of child poverty, the truth is that it extends far beyond stereotypical images of poor minority children in urban settings, with unemployed, welfare-receiving parents. The fact that, since 1981, the rate of child poverty in the US has stayed around 20% demonstrates that this is a mainstream problem, affecting children from all racial and ethnic backgrounds from all types of residential areas, and from all regions of the US.[41] Only one in six poor children lives in a family that relies exclusively on public assistance.[42] The majority of poor children live in families with one or more workers.[43]

Poverty can affect a child in many ways—in fact, it is often regarded as the primary risk factor that affects a child's life. Much research has shown that poverty can have a substantial detrimental effect on child and adolescent well-being. In addition to a greatly increased risk of problems involving health and education, children and adolescents who grow up in poverty are more likely to become single or teenaged parents, to earn less, to be unemployed more frequently as adults, and to grow up to be poor.

Being poor increases a child's likelihood of becoming ill and having serious illnesses. Low birth weight, asthma, dental disease,[44] prematurity, "preventable" diseases such as measles, and stunted growth are common among children in poverty, as are insufficient nutrition, hospitalization due to infectious diseases, chronic health problems, accidents and injuries, and long-term health problems.[45]

Which children are most at-risk for poverty? Young children, children who live with a single parent, children whose parents have low educational attainment and/or part-time or no employment, and children who live in rural areas.

Single parenthood is an important factor in determining the intensity and occurrence of child poverty. Following logic, research shows that children living with both parents have more than twice as much income available to them as children living with only one parent.[46]

Employment is not a guarantee to remove families from poverty. The numbers of "working poor" in our nation are growing. The growth in the number of poor children over the past few decades is not due to an increase in welfare-dependent families, but rather because of a surge in the ranks of the working poor: between 1976 and 1997, the number of poor children increased by about 3.3 million, and two-thirds of those children lived in families who had income from earnings but no income from welfare.[47] A March 2000 report by the Virginia Center for Research on Social Welfare Policy found that "employment is not a guarantee that low-wage earners in Virginia will escape poverty . . . . Being employed in a year-round, full-time job in Virginia did not enable 27.1% of poor families to escape poverty."[48] Another 2000 report, by the National Priorities Project, found that nearly 45% of the jobs in Virginia pay below the poverty guidelines. It is estimated that in Virginia, in the mid-1990s, there were 159,000 children living in working poor families.[49]

A parent's steady job reduces the likelihood of poverty and its accompanying risks for children. Secure employment not only provides dependable income for families, it also is often the source of health insurance for parents and children. It can enhance children's psychological well-being and help reduce stress and other negative factors associated with unemployment. One measure of secure parental employment is the percentage of children living with a parent who is employed full time. About one in four Virginia children lives with parents who do not have full-time, year-round employment.[50]

It is common to assume that poor children live in families where parents could work but do not. Yet this is not an accurate picture of poor families in the US. The majority of poor children live in families with one or more workers. In the mid-1990s, more than 80% of Virginia's poor families with children had at least one adult (of those who were not ill, disabled, or retired) working.[51]

Many of our nation's poor live in rural areas. The Census Bureau defines rural as places with 2,500 or fewer people; about one-fifth of the nation's poor families live in rural areas.[52] The 1990 Census provides the most recent count of Virginians living in rural areas, which is about 1.9 million, or about 31% of the Commonwealth's population. It also states that nearly 15% of all children living in rural Virginia live in poverty.

Poverty has been named one of the ten critical threats to American children today.[53] It is estimated that lifetime contributions to the economy by children currently in poverty will decline by an estimated $130 billion, because poor children tend to grow up to be less educated and less productive workers.[54] Unless poverty is reduced, the costs will be shared by employers and consumers, making it harder for businesses to expand technology, train workers, or produce high-quality products. Additional costs will be borne by schools, hospitals, our criminal justice system, and ultimately by taxpayers.[55] Poor children held back in school often require special education and tutoring. They experience a lifetime of heightened medical problems and reliance on social services, and they fail to earn and contribute as much in taxes.[56]

Information about the percent of children living in poverty in each locality in Virginia is not made available annually. The most recent statistics available are on the Census web site (www.census.gov/hhes/www/saipe.html).

Income Inequality

*It seems the saying "the rich get richer while the poor get poorer" may be a valid assessment of the US economy in recent years. The income gap is widening. After adjusting for inflation, nationwide, from the late 1970s to the late 1990s, the average income of the lowest-income fifth of families fell by more than 6%, and the average income of the highest-income fifth of families increased by more than 30%. * This type of income inequality—not simply the decline in the income levels of the poor—results in problems for society. Research has linked income inequality to poor health outcomes, poor schools, substandard housing, and higher levels of crime victimization. It has also shown that communities with above-average inequality have higher mortality rates than communities with comparable incomes and poverty but lower inequality. **

*Income inequality affects children's behavior in ways that are independent of their household income. The effect of inequality is due to the effect of other people's income. When the rich get richer, they benefit from positive interpersonal comparisons. However, as the poor get poorer, they suffer from more negative interpersonal comparisons. ***

*Is this inequality evident in the Commonwealth? Compared to the rest of the nation, Virginia is one of the ten most unequal states, in terms of income. The average income of the poorest one-fifth of Virginia families declined by about $700 from 1979 to 1997, while the average income of the wealthiest one-fifth of Virginia families increased by more than $35,000. In Virginia, the share of income held by the poorest one-fifth of families is about 5%; the share held by the wealthiest one-fifth is almost 45%. ***

* *Pulling Apart: A state-by-state analysis of income trends.* Center on Budget and Policy Priorities, Washington, DC, 1997.

**SE Mayer. "How did the increase in economic inequality between 1970 and 1990 affect American children's educational attainment?", working paper, Joint Center for Poverty Research.

Other Issues

The health of young people—and the adults they will become—is critically linked to the health-related behaviors they choose to adopt. These behaviors, often established during youth, include tobacco use; unhealthy dietary behaviors and inadequate physical activity; alcohol and other drug use; sexual behaviors that may result in HIV (human immunodeficiency) infection or other sexually transmitted diseases or in unplanned pregnancies; and behaviors that may result in intentional injuries (such as violence and suicide) and unintentional injuries (motor vehicle crashes).

Tobacco usage by young people is a particular health care concern. A number of factors in young people's lives seem to affect the likelihood that an adolescent will use tobacco. Studies reveal links between adolescent smoking and negative childhood experiences, such as emotional or physical abuse or witnessing domestic violence. School performance also has an effect; research has shown the better a student does academically, the less likely he or she is to become a smoker.[57]

Cigarette smoking is on the rise among adolescents in the US, but the National Center for Health Statistics reports that the prevalence of smoking has remained consistently higher among white adolescents. The American Legacy Foundation states that about 13% of middle school students, and 35% of high school students use tobacco products regularly (including smokeless).

Cigarette sales to children and adolescents are substantial. In 1997, the five largest tobacco companies earned an estimated $480 milion in profit from cigarettes smoked by people under the age of 18, according to the *American Journal of Public Health.*

Childhood habits impact lifelong behaviors; the American Legacy Foundation reports that almost 90% of adult smokers began before age 18. The Centers for Disease Control and Prevention state that each day, more than 3,000 children become regular smokers; roughly one-third of them will eventually die from a tobacco-related disease. They also found that, in 1990, the average age of a child who tried cigarettes was younger than 12 years. Studies suggest that anyone who does not begin to use tobacco as a child or adolescent is unlikely to start as an adult.

Cigarette smoking is the single most preventable cause of death in the US, according to the US Department of Health and Human Services. It has been shown to be tied to other substance abuses and negative outcomes. For instance, the 1995 National Household Survey on Drug Use (by the Substance Abuse and Mental Health Services) found that 12- to-17-year-olds who smoke cigarettes are about 8 times as likely to use illicit drugs and 11 times as likely to drink heavily as nonsmoking youth. The National Center for Chronic Disease Prevention and Health Promotion reports that teens who smoke tobacco products are 3 times more likely than nonsmokers to use alcohol, 8 times more likely to use marijuana, and 22 times more likely to use cocaine, and that teenage smokers are more likely to have seen a doctor or other health professional for a psychological or emotional complaint.

The National Institute of Mental Health and the National Institute on Drug Abuse funded a study that found that teen smokers are prone to anxiety disorders in adulthood. In this study, teens who smoked 20 or more cigarettes daily were more than 15 times more likely to develop panic disorder, nearly 7 times

more likely to fear public places, and more than 5 times more likely to develop generalized anxiety disorder than teens who smoked less or not at all. The Surgeon General's Report on tobacco use among young people concluded that "tobacco use in adolescence is associated with a range of health-compromising behaviors, including being involved in fights, carrying weapons, engaging in higher risk sexual behavior, and using alcohol and other drugs."

Younger adolescents are at risk for experimenting with tobacco and then becoming regular smokers. The peak ages for trying cigarettes and smokeless tobacco are those in junior high school (12-14 year olds). Older, white male adolescents (15-17 years old) are more likely to become regular users of smokeless tobacco.[58]

Nutrition and Exercise

The lack of good nutrition and exercise habits can result in health problems for children. Lifelong physical and emotional problems may plague children who experience poor nutrition.

In addition to affecting physical growth and health, research shows a clear connection between nutrition and learning, that children and youths will be ready to learn and will achieve their fullest potential only if they are well nourished and healthy. Such children have better attendance at school, concentrate more on their lessons, and achieve improved performance.

The Centers for Disease Control and Prevention report that childhood overweight is the leading cause of pediatric hypertension, and overweight children are at high risk for developing some long-term chronic conditions, including diabetes, heart disease, orthopedic disorders, and respiratory disorders. Nationally, the high prevalence of overweight among children has been well documented in national surveys since the mid-1970s.

Research shows that overweight adolescents are likely to become overweight adults. Inherent in that is the susceptibility to numerous health problems, including hypertension, coronary heart disease, gallbladder disease, diabetes, and some cancers. The US Department of Health and Human Services reports that the percentage of 6- to 17-year-olds who are overweight has more than doubled since the 1960s.

A study cited by the American Academy of Pediatrics reports that, since the 1970s, the prevalence of overweight has increased among 4- and 5-year-old children, suggesting that efforts to prevent overweight begin with preschool-aged children.

Chronic undernutrition, usually a result of poverty, compromises children's cognitive and social development. However, even children from homes with adequate incomes can experience transient hunger that affects their daily ability to learn or suffer from malnutrition because of poor food choices.

The Centers for Disease Control and Prevention report that poor eating habits are often established during childhood; that more than 60% of young people eat too much fat, and that more than 80% do not eat the recommended number of fruits and vegetables each day. Even mildly undernourished children may suffer abnormal brain, cognitive, and psychological impairment that, if not corrected, can be irreversible. Children not receiving proper nutrition during the brain's most formative years score much lower on tests of vocabulary, reading comprehension, and general knowledge.[59] Recent research conducted at Tufts University found compelling evidence that improved nutrition can modify and even reverse these effects.[60]

Research by the Centers for Disease Control and Prevention has found that more than one-third of young people (ages 12 to 21) do not regularly engage in vigorous physical activity. Daily participation in high school physical education classes dropped by about half during the 1990s.

Previously, KIDS COUNT in Virginia provided information on the percent of middle school students who passed all four spring physical fitness tests. However, in Virginia, these data are no longer collected by the Department of Education, because it is no longer public information. The Commonwealth does collect data regarding students' upper body wellness for each locality.

The impact of the **HIV/AIDS** epidemic on young people is substantial: half of all new HIV infections are estimated to occur among young people under the age of 25. Although most teenagers say that HIV/AIDS is a serious problem they are concerned about, more than two-thirds would not know where to go to get tested, according to a White House report, *Youth and HIV/AIDS 2000: A New American Agenda.*

(KIDS COUNT in Virginia previously tracked the incidences of sexually transmitted diseases among teenagers in the Commonwealth; this indicator is no longer monitored by this project, primarily due to reporting discrepancies.)

Dental Health

Tooth decay is one of the most prevalent chronic illnesses facing children in the US today. It is estimated that children miss 52 million hours of school each year due to dental problems. The first-ever Surgeon General's report on oral health (May 2000) found that children are among those who suffer the worst oral health in the nation. Economic factors related to dental care—such as insurance and access to care—were cited as major contributors to this "silent epidemic" of poor oral health in the US.

Dental caries (decay in one or more teeth) may indicate a lack of access to preventive care or a lack of information about preventive techniques. Additionally, children who do not receive treatment for this decay may experience pain and suffering, and the functioning of their teeth may be permanently harmed. The prevalence of tooth decay is disproportionately concentrated among children from low-income families; for instance, among children 2 to 5, poor children are more than twice as likely to have dental decay.[61]

How well-equipped is the Commonwealth to handle the dental care needs of its citizens? The Centers for Disease Control and Prevention reported that in 2000 in Virginia, there were approximately 3,500 licensed dentists; 10 community-based, low-income dental clinics; and 59 district/county/local health departments with a dental program, and that the population for the Commonwealth was about 6 million. (A number was not available for Virginia's community health centers with dental clinics nor the percent of dentists participating in the Medicaid Dental Program.)

The Centers for Disease Control and Prevention also report that, during 1999, fewer than 72% of all Virginians visited a dentist or dental clinic, and that nearly 30% of all Virginians had lost all of their teeth.

Virginia is one of a few states that does not regularly survey its young people about their drug and alcohol use (or other risky behaviors). The most recent such surveys (the Virginia Student Survey and the Youth Risk Behavior Survey) were conducted in the late 1980s and early 1990s. Because statewide survey efforts ceased after 1993, many localities have conducted their own survey efforts to measure alcohol and drug use by local youth. Slightly more than 80% of school divisions in the Commonwealth report administering their own survey within the past ten years, meaning there is considerable variation in survey methods and content among localities; therefore, the findings cannot be used to produce statewide estimates or to make comparisons between localities. The data that are available (primarily arrest reports and students caught with alcohol or drugs on school grounds) represent only the youth who have been formally identified through legal or educational procedures as being involved with drugs and alcohol. These data do not include youth who may be at earlier stages of drug involvement or youth who have engaged in substance use without being detected by authorities. It should also be noted that differences between localities may reflect differences in the detection and reporting of drug and alcohol-related offenses. For these reasons, comparisons between localities should be made with caution.

(Information from House Document No. 51, A Review of Virginia Youth Drug and Alcohol Survey Efforts, Commonwealth of Virginia, Richmond; final report of the Department of Criminal Justice Services to the Governor and the General Assembly)

Drug and alcohol use are on the rise among children and adolescents. Drug use contributes to crime, decreases economic productivity, and requires a disproportionate share of health care services for those affected. Use of drugs has been linked to many health and cognitive risks.

A study conducted at Columbia University found that adolescents in small-town and rural America are much more likely than their peers in urban centers to have used drugs, and that 8th graders in rural areas are 83% more likely to use crack cocaine, and 34% more likely to smoke marijuana than their urban counterparts.

Research conducted by the Kaiser Family Foundation and by the National Center on Addiction and Substance Abuse shows that teens who drink alcohol or use drugs are more likely to have sexual relations and initiate them at younger ages—as early as middle school—and have multiple partners, placing them at higher risk for sexually-transmitted diseases and unplanned pregnancies.

The 2000 National Longitudinal Study of Adolescent Health (which is ongoing and began in 1994) found that a large number of young people have a drinking problem. One of every 10 young people say they drink weekly. Younger teens are not immune: 1 of 12 pre-adolescents said they drank two to three times a month, and more than 1 of 4 said they had had a drink within the past year. The proportions for girls were the same as for boys.

Alcohol use among adolescents is linked to a host of problems, including motor vehicle crashes and deaths, difficulties in school and the workplace, fighting, and breaking the law. The National Institute on

Alcohol Abuse and Alcoholism finds that the younger the age of drinking onset, the greater the chance that an individual at some point in life will develop a clinically defined alcohol disorder.

Previously, KIDS COUNT in Virginia tracked statistics that indicated the numbers of students found to have alcohol or drugs on school grounds. This indicator has been discontinued by this project, because it only reflects the young people who have been formally identified through the educational system as having been involved with drugs and alcohol. These data do not fully represent a locality's drug and alcohol abuse by young people.

Insurance

In 1997, the US Congress authorized a state children's health insurance program for children from working families whose income is too high to qualify for Medicaid but too low to be able to afford an unsubsidized health insurance premium. Since that time, all 50 states and the District of Columbia have acted to implement their programs. A state can choose to operate its children's health insurance as a Medicaid expansion, as a separate stand-alone program (which is what Virginia offers in the form of Children's Medical Security Insurance Plan, or CMSIP), or it can concurrently operate both Medicaid expansion and a separate child enrollment program. For more information about CMSIP, including locality-specific information on enrollment, visit the web site for Project SignUpNow (www.vakids.org/SUN). They can also be contacted at PO Box 31394, Richmond, VA 23294-1394 or 804-965-1352.

Additional Topics

Homelessness is defined as lacking a fixed, regular, and adequate nighttime residence. Research has shown that homeless families relocate 16 more times than the typical American family, that half of all children in need of shelter do not receive it, that frequent moves decrease the likelihood that homeless children will receive the special education services they may require, and that nearly half of school-aged children experience depression, anxiety, or aggression after becoming homeless.[62]

How many children in Virginia are homeless? No single data source captures the number of homeless children, but Project HOPE (the Virginia Education for Homeless Children and Youth Program) conducts a regular survey of public schools, central offices for local school divisions, shelters and transitional housing programs, and other service providers. Their latest findings are for the period between July 1999 and June 2000; they found that approximately 17,000 children and youth were identified as being homeless in the Commonwealth, a 30% increase over their 1996-97 report. Because almost as many people are turned away—due to lack of space in homeless shelters—as are served, it can be assumed that the numbers of children sheltered is an underreport of the actual incidence of homelessness.

Project HOPE may be contacted at The College of William and Mary, School of Education, Jones Hall, PO Box 8795, Williamsburg, VA 23187-8795, or 757-221-4002; their web address is http://www.wm.edu/education/HOPE/Homeles.html.

Family Stress

Much research has shown that stressful events and life circumstances can have adverse physical and psychological effects on children and adolescents. The Urban Institute reports that more than one of five children in the US live in a stressful family environment, defined as the presence of two or more of the following stressors: the inability to pay bills or obtain food throughout the month; overcrowding in the home (such as more than 2 people per bedroom in the household); uncertainty about health care; or a family member who is in poor health or has a physical, learning, or mental health condition. The likelihood of family stress is greatly increased if the family lives below the federal poverty level.

When parents are preoccupied with stressful circumstances, they may be less able to provide optimal home environments for their children, and, when overwhelmed, may even become harsh or coercive toward their children. At worst, stress in families can contribute to violent or abusive environments.

- *Summarized from* Stressful Family Lives: Child and Parent Well-Being, *New Federalism: National Survey of America's Families, Series B, No. B-17, June 2000.*

Turbulence in a Child's Life

Change often has an unsettling effect on children, creating a turbulence in their lives. Children who move from school to school are less academically successful than are children who do not change schools. Social and cognitive development are lower among children experiencing repeated changes in their child care, compared to children who have a stable provider. Also, changes in household structure and family composition are associated with increased problems for children, and children whose families frequently change their residence tend to face greater developmental challenges. It turns out that when more than one of these changes—moving from one state to another; moving to a different home; moving in with another family; two or more changes in employment by either a parent or a parent's spouse; two or more school changes; or a significant decline in the health of the child, parent, or parent's spouse—occur together, the effects on children can be especially damaging.

Children respond differently when subjected to many changes—most likely to be impacted negatively are children who live in poor families, children who receive public assistance, children who live with an unmarried parent, and children whose parents did not complete high school.

- *Summarized from* Turbulence and Child Well-Being, *New Federalism: National Survey of America's Families, Series B, No. B-16, June 2000.*

References/end notes for text:

1 National Institute of Justice, Washington DC. US Department of Justice.
2 Schorr LB. (1988). *Within our reach: Breaking the cycle of disadvantage.* New York: Doubleday.
3 Barr RD & Parrett WH. (1995). *Hope at last for at-risk youth.* Needham Heights, MA: Allyn & Bacon.
4 *Trends in the Well-Being of America's Children and Youth, 2000.* US Department of Health & Human Services.
5 Dryfoos J. (1997). Prevalence of problem behaviors: Implications for programs. In: RP Weisburg et al (eds.) *Enhancing children's wellness.* London: Sage.
6 National Campaign to Prevent Teen Pregnancy.
7 Robin Hood Foundation, 1996.
8 *When Teens Have Sex: Issues and Trends,* KIDS COUNT Special Report. Baltimore, MD: Annie E. Casey Foundation, 1998.
9 Collins A & Aber JL. *How welfare reform can help or hurt children,* Issue Brief 1. National Center for Children in Poverty, 1997.
10 Census Bureau media release (#CB99-77), April 23, 1999.
11 *Why Rural Matters.* Rural School and Community Trust, August 2000.
12 Levine PB & Zimmerman D. Children's welfare exposure and subsequent development, Policy Brief Volume 2, No. 8. Northwestern University/University of Chicago: Joint Center for Poverty Research.
13 Edin K & Lein L. (1997). *Making ends meet: How single mothers survive welfare and low-wage work.* New York: Russell Sage Foundation.
14 Virginia Center for Research in Social Welfare Policy, National Priorities Project, and *Poverty despite work handbook.*
15 "Children in poverty, family income, and public policy" - special report, University of Pittsburgh Office of Child Development, March 1997.
16 Auxiliary tables for the 2000 National KIDS COUNT Data Book, May 2000. Baltimore, MD: Annie E. Casey Foundation.
17 The Center for Mental Health Services, http://www.mentalhealth.org/publications/allpubs/ca-0004/c&amh.htm.
18 The Center for Mental Health Services, http://www.mentalhealth.org/publications/allpubs//CA-0031/ccmhse.htm.
19 Hyman SE. "Thinking About Violence in Our Schools," discussion at the White House, August 3, 1998. National Institute of Mental Health.
20 Children and Family Services Council. (1999). Position paper, "Virginia's continuing policy to take away state psychiatric hospitals for children without increasing community service options."
21 Community Services Board Planning Council. (1999). "The impact of downsizing Virginia's state psychiatric hospitals for children without increasing community service options."
22 Children's Defense Fund. "Meeting children's unique mental health needs," March 14, 1998.
23 US Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.*
24 *Ibid.*
25 *Ibid.*
26 *Ibid.*
27 *Ibid.*
28 Commission on Violence and Youth. (1993). *A summary of Violence and Youth.* Report of the American Psychological Association.
29 Eron LD *et al.* (1994). *Reason to hope.* American Psychological Association.
30 *Ibid.*
31 Smith S *et al. America's youth: Measuring the risk.* Washington, DC: Institute for Youth Development.
32 Cornell DC *et al.* (1999). *Youth violence prevention in Virginia: A needs assessment.* Charlottesville, VA: Curry School of Education, University of Virginia, for the Virginia Department of Health.
33 Carter J. (1999). Paper, "Domestic violence, child abuse, and youth violence" for the Family Violence Prevention Fund of San Francisco, California.
34 Edleson J. (1995). Presentation, "Mothers and children: understanding the links between woman battering and child abuse" for the National Institute of Justice.
35 Virginia Institute for Developmental Disabilities (VIDD) reference - Sullivan and Knutson, 2000.
36 *Ibid.*
37 VIDD.
38 VIDD reference - McGarvey and Waite, 2000.
39 VIDD.
40 National 2000 KIDS COUNT Data Book. Baltimore, MD: Annie E. Casey Foundation.

41 National Center for Children in Poverty. *Early childhood poverty: A statistical profile.*
42 National Center for Children in Poverty. *Young children in poverty: A statistical update*, 1999.
43 Lazere E for Center on Budget and Policy Priorities. (1997). *Poverty Despite Work Handbook.*
44 St Pierre RG and Layzer RG. "Improving the life chances of children in poverty: Assumptions and what we have learned." *Social Policy Report*, Vol. XII, No. 4, 1998.
45 Collins A & Aber JL. "How welfare reform can help or hurt children," Issue Brief 1, 1997, for the National Center for Children in Poverty.
46 *Young children in poverty.*
47 National League of Cities, Joe DiMaggio Children's Hospital, Youth Crime Watch of America, National Child Advocates Association and National School Boards Association. (1999)."Ten critical threats to America's children: Warning signs for the next millenium."
48 Virginia Center for Research on Social Welfare Policy. (March 2000). "It takes more than a job: The outlook for Virginians leaving welfare." Falls Church, VA.
49 *Poverty despite work handbook.*
50 2000 National KIDS COUNT Data Book.
51 *Poverty despite work handbook.*
52 Jensen L. (1996). *Demographics of rural poverty.* National Regional Center for Rural Development. University Park, PA: Pennsylvania State University.
53 "Ten critical threats."
54 Children's Defense Fund. *Poverty matters: The cost of child poverty in America.*
55 *Ibid.*
56 *Ibid.*
57 *The Youth Connection*, Jan/Feb 2000, published by the Institute for Youth Development, Washington, DC.
58 *Ibid.*
59 National Center for Children in Poverty. *Poverty and brain development in early childhood.*
60 America's Second Harvest. *Childhood hunger.*
61 Children's Oral Health - facts produced by the Centers for Disease Control and Prevention.
62 "Homeless in America: A children's story," a report from Homes for the Homeless and the Institute for Children and Poverty, 1999.

OTHER SOURCES CONSULTED:

1998 National KIDS COUNT Data Book, Annie E. Casey Foundation (Baltimore, MD).
2000-2001 KIDS COUNT in Delaware Fact Book, Center for Community Development and Family Policy (Newark, DE).
Quality Child Care in Virginia white paper, Action Alliance for Virginia's Children and Youth (Richmond, VA).
Affordability and Accessibility of Child Care in Virginia white paper, Action Alliance for Virginia's Children and Youth (Richmond, VA).

WHAT IS KIDS COUNT?

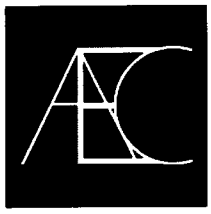
Now in its sixth year, the KIDS COUNT in Virginia program monitors changing trends that affect the well-being of children in the Commonwealth, and conveys that information through projects such as the 2001 KIDS COUNT in Virginia database and data book.

The program is administered by the Action Alliance for Virginia's Children and Youth (see pages 54-55 for more information).

KIDS COUNT has two meanings—it is a "count," or an assessment, of factors related to children's well-being; and it shows that young people "matter" in our Commonwealth.

The information that KIDS COUNT in Virginia provides is important because it allows localities to evaluate reliable, objective measures that help determine how they are serving the needs of families and children in their communities. The information can then be used to monitor progress that communities have made or need to make as they evaluate circumstances affecting the lives of their young people.

In addition to this data book and the 2001 database, KIDS COUNT in Virginia also produces other publications and conducts other educational activities. For more information, visit the Action Alliance web site (www.vakids.org & click on "KIDS COUNT"), or contact us at 701 East Franklin Street, Suite 807, Richmond, VA 23219, or 804-649-0184, or actionalliance@vakids.org.



The Annie E. Casey Foundation

The Annie E. Casey Foundation initiated and maintains the KIDS COUNT project, which is a national and state-by-state effort to track the status of children in the United States. The Foundation produces annual national KIDS COUNT data books and special reports, as well as oversees KIDS COUNT projects in each state, the District of Columbia, and the US Virgin Islands. The Action Alliance is the Foundation's grantee for KIDS COUNT in Virginia.

For more than half a century, the Foundation has worked to build better futures for disadvantaged children and their families; their mission is to foster public policies, human service reforms, and community supports that more effectively meet the needs of today's vulnerable children and families. Working with neighborhoods and state and local governments, the Foundation provides grants to public and nonprofit organizations to strengthen the overall well-being of distressed communities.

By providing policymakers and citizens with benchmarks of child well-being, the Foundation—through KIDS COUNT—seeks to enrich local, state, and national discussions concerning ways to secure better futures for all children. At the national level, the principal activity of the initiative is the publication of the annual national KIDS COUNT Data Book, which uses the best available data to measure the educational, social, economic, and physical well-being of children, on a state-by-state level. The grantee projects in the national network provide a more detailed community-by-community picture of the condition of children.

In addition to national KIDS COUNT data books, the Foundation also produces special reports on topics such as birth-related data and teen sexual activity. Other major activities of the Foundation include Casey Family Services, Neighborhood Transformation/Family Development, Family to Family, Jobs Initiative, Rebuilding Communities Initiative, and the Juvenile Detention Alternatives Initiative. Additional publications are the Casey Connects newsletter and ADVOCASEY, an online and print magazine.

For more information on the Foundation, its national data books, its other publications, its activities, or the KIDS COUNT project, visit their web site at www.aecf.org, or contact them at 701 St. Paul Street, Baltimore, MD 21202, or 410-547-6600.

The Action Alliance for Virginia's Children and Youth is the home and primary support of KIDS COUNT in Virginia. Nonprofit and non-partisan, the Action Alliance is the Commonwealth's only multiple-issue, statewide, child advocacy organization. Currently, the Action Alliance focuses on three priority areas: the prevention of violence, children's health (presently with an emphasis on mental health issues), and early care and education.

The mission of the Action Alliance is to build a powerful voice for children and to inspire the people of Virginia to act on their behalf.

Good policies for children and wise decisions to implement these policies must be based on accurate, objective information, rather than on biased data or atypical anecdotes. Providing, interpreting, and disseminating that information is essential to the work of the Action Alliance and its KIDS COUNT in Virginia program. Also integral to the Action Alliance's work is monitoring legislation and policies that affect children and establishing a statewide network to enhance the well-being of Virginia's children and families.

The Action Alliance is a unique catalyst in implementing far-reaching, positive change for the children of the Commonwealth—through expertise in connecting resources, in providing accurate information, and in educating key groups and individuals. Through different educational and advocacy efforts, the Action Alliance, a membership organization, works to help all children grow into healthy, productive adults and to empower and inspire thousands to make life better for our most valuable resource—our children.

Contact information for the Action Alliance:
701 East Franklin Street, Suite 807
Richmond, VA 23219
Tel.: (804) 649-0184 FAX: (804) 649-0161
e-mail: actionalliance@vakids.org
web site: www.vakids.org

The Action Alliance is governed by a volunteer Board of Directors, representing multiple interests and geographic regions around the Commonwealth. The current members are:

Jeannie P. Baliles
Richmond

Wyatt Beazley, III, MD
Richmond

E. Cabell Brand
Salem

Michelle Barrett Ferrier
Emory

Hugh F. Gouldthorpe, Jr.
Richmond

Virginia R. Holton
Weems

Carroll Hurst
Richmond

Patricia R. Hutcherson
Vienna

Maria F. Keritsis
Richmond

William S. King
Richmond

Janet Miller Kreutter
McLean

William J. Pantele, Esq.
Richmond

Xavier R. Richardson
Fredericksburg

Rebecca Riddle-Whitlow
Buffalo Junction

J. David Robinson
Herndon

Rosel Schewel
Lynchburg

Jane Whitt Sellers, Esq.
Richmond

Robert E. Shepherd, Jr.
Richmond

Charles P. Shimer, Esq.
Richmond

Kent A.P. Smith
Richmond

Elizabeth S. Wash
Hampton

Charlene A. Wheeless
Reston

Some ongoing programs and projects of the Action Alliance are:

- KIDS COUNT in Virginia
- TEACH-VA
- Coalitions on children's health, mental health, violence, and child care
- Beat the Odds scholarship event
- *Children's Voice* newsletter
- First Things First campaign
- KIDS COUNT Leaders' Institute
- Child Advocacy Day

Ten Critical Threats to America's Children: Warning Signs for the Next Millenium

> *"As surely as any enemy America has ever confronted in war, these critical threats jeopardize our way of life . . . . The warning signs and solutions are important for all of us together, and not just for our children. Their future is in our hands, and ultimately, our future will be in their hands."*

In November 1999, a coalition of national leadership groups (the National League of Cities, the National School Boards Association, Youth Crime Watch of America, Joe DiMaggio Children's Hospital, and the National Association of Child Advocates) presented a detailed report that outlined some factors that jeopardize the health, safety, and future of our children.

The goal of the report is to generate greater recognition of these problems, to establish and maintain a dialogue about them, and to develop a network of community partners to offer the best possible conditions for children.

All of the threats addressed in the report are documented by research, and are accompanied by suggested solutions (which range from legislative action to expand current assistance programs for working poor families to more active parental roles in monitoring how and where their children spend time and what kind of television programs they watch). The critical threats and the accompanying narrative (developed by the coalition) follow:

The Plague of Poverty — One in five American children lives in poverty. As a result, their lifetime contribution to the economy will decline by an estimated $130 billion because poor kids grow up to be less educated and less productive workers. Children growing up poor are much more likely to experience an array of problems regarding their health, emotional well-being, school readiness and achievement, and their employability as adults.
Solutions: Programs that help working poor parents gain better access to child care and health care and expand access to higher education and capital can help. There is also a need for higher family incomes, which can be attained by raising the minimum wage, better outreach efforts by subsidized programs, and better enforcement of child support payment laws.

Abuse and Neglect at Home — The legacy of child abuse and neglect is seen starkly in the experiences of the 25,000 to 30,000 young people who leave foster care each year to take on the responsibilities of adult life, either by reaching 18 or by being emancipated. Within one year, 25-40% experience homelessness, only 40-50% will have completed high school, and fewer than half will have jobs; and more than 60% of the young women will have babies within four years.
Solutions: We must offer more quality out-of-home care for abused children and streamline the adoption process to provide children a sense of permanency more quickly. We also must address the drug and alcohol problems of adults that often fuel episodes of abuse and neglect.

Violent Crime — Violent juvenile crime arrests in America have fallen 25% since 1994, in part due to tougher laws. However, public concern remains high because of the volume and visibility of crimes involving children, both as victims and perpetrators. In 1997, law enforcement agencies made about 2.8 million arrests of youths under the age of 18.
Solutions: Parents and other supervising adults must take additional steps to make sure that guns and other weapons stay out of the hands of children. Schools and communities must offer more quality after-school programs—for all ages—to ensure children are spending their time productively and not getting into trouble on the streets. Promoting parental involvement at schools and in the community are other ways of preventing juvenile crime.

Dangerous Escapes — The 1998 National Household Survey on Drug Abuse showed that overall, during the 1990s, there was a rise in drug use among youths ages 12-17. The teen years are also a time of sexual experimentation. More than half of girls and three-fourths of boys under age 18 are sexually active, and each year, three million American teens are infected with AIDS, HIV, and other sexually transmitted diseases.
Solutions: The most effective way of preventing drug, alcohol, and tobacco abuse is by educating parents, teachers, and school-aged children about the signs, symptoms, and dangers. Parents can influence their children by not using harmful substances themselves. Youth should receive information from their parents and their communities that supports their decision to abstain from sex.

Children Having Children — Every year in America, one million teenage girls become pregnant, and about half give birth. Studies have suggested that 43% of all teenage girls in this country will become pregnant at least once before they reach the age of 20. And, according to a report by the National Academy of Sciences' Institute of Medicine, more than 80% of teenage pregnancies are either mistimed or unwanted.
Solutions: Although teen pregnancy and birth rates have declined in America, they are still far too high. Youth should receive information that supports their decision to abstain from sex and should be encouraged to ask their parents or other trusted family member for information. Human service professionals must be better trained in issues of teen pregnancy prevention.

Inadequate Child Care — About 65% of mothers with children under 6 years old, and 78% of women with children between the ages of 6 and 17 are in the labor force, creating a necessity for affordable, quality child care, but that can be difficult to find. An alarming percentage of the child care in America is "poor" to "mediocre." One four-state study found that 40% of the rooms serving infants in child care centers were so poorly run that they actually put at risk children's health, safety, and development.
Solutions: Polls show many Americans support additional tax breaks for enrolling their children in child care. Schools and communities can also establish scholarship funds to assist families who need help paying for child care. The public and private sectors must step up to the challenge by fully funding quality programs.

Absent Parents — In many families today, it is necessary for both parents to work, making it even more difficult for parents to know what their children are doing, with whom they are spending time, and what they are thinking. Every day, nearly 5 million children come home to an empty house because their parents are working, and in many instances, there's nothing parents can do about it. It is during the 3-7 p.m. period when juvenile crime and victimization peaks in America.
Solutions: Parents must understand what messages in the media are influencing their children and be prepared to talk through sensitive subjects. They must take the time to ensure, as much as possible, that their children are engaged in supervised, healthy activities.

Lack of Health Care — In 1998, an estimated 11.1 million children under 18 had no health insurance. The percentage of children not covered by health insurance has been on the rise. Children suffering from untreated illnesses often are not ready to learn, and, thus, struggle to keep up in school. One study found that uninsured children were 25% more likely to miss school than kids who were insured.
Solutions: Accessible, affordable, and comprehensive health care for all children is critical to ensuring the societal health of America. Until that happens, we must preserve the federal guarantee of Medicaid for all poor children, take additional steps to enroll those children who are eligible yet not participating. We must improve Medicaid benefits and broader health insurance coverage for uninsured children, and oppose efforts to sacrifice good coverage for wider, inadequate coverage.

New Pressures in the Classroom — America's elementary and secondary schools face a variety of complex challenges in educating our children in the next millenium. From spotty academic performance and overcrowded classrooms to continuing high dropout rates and threats and fears of violence on campus, children face pressures never seen before in the classroom.
Solutions: Schools must receive adequate levels of state and federal funding to improve academic scores for all students and reduce class sizes as well as receive adequate resources to provide for the increasing numbers of students enrolled in special education programs. Parents, schools, and communities must work cooperatively to identify at-risk students and direct them to alternative learning programs to prevent them from leaving school.

Dangers in the Environment — Every day, children are exposed to known carcinogens, neurotoxic substances such as lead and mercury and potentially dangerous pesticides. These substances can lead to serious developmental problems in children, and in extreme cases, even death. Lead, mercury, and polychlorinated biphenyls (PCBs) are among the substances suspected of having harmful and perhaps permanent neurological effects on children.
Solutions: For our children, we must work to protect the air that we breathe, the water that we drink, and the land that we live on. Communities should dedicate additional resources toward surveying older homes—particularly those of the poor—to determine if lead-based paints are endangering children. Pesticide makers should better educate parents about the potential health risks of common pesticides used indoors and out.

The Right Start . . . in Virginia

The Annie E. Casey Foundation (in conjunction with Child Trends) recently issued a special report about birth-related data called *The Right Start: State Trends (Conditions of Babies and Their Families Across the Nation, 1990-1998)**. Following is a summary of the findings about Virginia in that report.

The yearly number of births in Virginia declined from 1990 to 1998.

Overall, Virginia has done better than the nation as a whole on most measures included.

Fewer teens in Virginia are giving birth, yet more unmarried women are.

Nearly 1 of 3 young Virginians is born to a single mother, which greatly increases the risks of adverse birth outcomes, of being poor, and of becoming single parents themselves.

During the years covered in the report (1990-1998), Virginia showed improvement in five of eight measures, including the percent of total births to teens, the percent of teen births to women who were already mothers, the percent of total births to mothers with less than 12 years of education, the percent of total births to mothers receiving late or no prenatal care, and the percent of total births to mothers who smoked during pregnancy. However, the Commonwealth worsened in three areas, including the percent of total births to unmarried women, the percent of low birth-weight babies born, and the percent of preterm births.

The report can be downloaded or ordered on the Annie E. Casey Foundation web site (www.aecf.org).

*They also issued a *Right Start* report about trends in the nation's 50 largest cities. Virginia Beach is the only city in the Commonwealth to be included.

OTHER FACTS ABOUT VIRGINIA

- The average household in Virginia is made up of 2.61 persons.[a]
- There are 39,598 square miles in the Commonwealth; in 1999, there were nearly 174 persons per square mile.[a]
- There were 95,207 live births in the Commonwealth in 1999.[b]
- The youngest mother to give birth in Virginia in 1998 was 11 years old; the youngest father was 14 years old.[b]
- In a recent assessment of all states, Virginia ranked 50th in the median hourly wage paid to child care workers as a percent of all workers' wages. The median hourly wage paid to child care staff in Virginia (average $6.22/hour) is only 51% of that paid to all other workers (average $12.14/hour).[c]
- More than 2,500 Virginia juveniles are incarcerated. Only six states put a larger percentage of young people in jails or prisons than Virginia, although the Commonwealth's juvenile crime rate is below the national average.[d]
- Many experts say the future belongs to those on the Internet and those who can compete in a global economy. Based on this assessment, many Virginia children and families don't have a claim on the future: in homes in the Commonwealth, 1 in 20 children have no telephones; nearly half have no computers; and more than two-thirds have no Internet access.[e]
- From 1990 to 1997, the number of Virginia teenagers who died due to accidents decreased; the number of teenagers who committed suicide increased; and the number of teenagers who were victims of homicides remained the same.[e]

Sources

[a] 1990 US Census
[b] Virginia Department of Health
[c] Auxiliary tables, 2000 National KIDS COUNT Data Book
[d] *Richmond Times-Dispatch*, October 17, 1999
[e] 2000 National KIDS COUNT Data Book

The following are available from the Action Alliance for Virginia's Children and Youth:

(single copies are available at no charge; many of these publications are available on the Action Alliance web site - www.vakids.org and click on "kids count.")

White papers on critical issues in child care.
This is an ongoing series of white papers detailing critical issues in child care in the Commonwealth. Each paper will have a strong data and research base, using hard-to-find Virginia specific data wherever possible.

Quality Child Care [June 1998, 20 pages]
Affordability and Accessibility [April 1999, 29 pages]
Child Care and Business [in press]

Special Report - *An Overview: Children and Violence.*
This is a special report outlining the important issue of violence in the lives of our children. [December 1999, 16 pages]

***A Directory of Information Sources about Children and Families* - 2000.**
This *Directory* contains contact information for nearly 70 sources of data and information about children and families. [March 2000, 16 pages]

A Guide to Using Data for Effective Advocacy.
This practical guide explains how to use data to strengthen your case. [March 2000, 8 pages]

Special Report - *Issues in Children's Mental Health.*
This special report covers many Virginia-specific topics, such as the delivery of mental health services, the scope of the problem, and issues affecting the availability and accessibility of services. [October 2000, 20 pages]

To receive any of these,
or for information on the organization or membership,
contact the Action Alliance at
701 East Franklin Street, Suite 807, Richmond, VA 23219
Tel.: (804) 649-0184; FAX: (804) 649-0161
e-mail: actionalliance@vakids.org
web site: www.vakids.org

The 2001 KIDS COUNT in Virginia data project (consisting of an online database and this data book) would not be possible without the generous support of the following:

The Annie E. Casey Foundation
Children's Hospital of The King's Daughters
Inova Health System
Carilion Medical Center for Children

Produced by the

Action Alliance

for Virginia's Children & Youth

2001 KIDS COUNT in Virginia is supported by:

Children's Hospital of The King's Daughters

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

Reproduction Basis

☒ This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

☐ This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").

EFF-089 (3/2000)